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ABSTRACT

As an alternative to unnecessary inpatient care of adults with orthopedic disabilities, the Independent Living Project (ILP) placed persons who were institutionalized without need and persons who were living in the community under unsatisfactory circumstances in foster homes. Information is presented on the intake procedures, homefinding techniques, matching client to foster home problems, counseling services, and the employment procedures used in the project. The characteristics of the ILP clients and foster families and the effects of social work intervention are enumerated with summary tables of data clarifying the placement results. Nine major areas of concern were identified. Each area is delineated with a list of recommendations and implications. These include the procedures for moving the disabled into suitable environments, the applicability of foster homes for the disabled, the alternatives for living environments, the opportunity to participate in training for social skills, the compilation of a central record file or data bank, the effect of the work experience and its importance, the cooperation of community organizations for the disabled, the need for the coordination of personnel services, the allocation of personnel and types of services offered, and final conclusions. (WW)

NEW YORK SERVICE FOR ORTHOPEDICALLY HANDICAPPED

INDEPENDENT LIVING

A Study of the Rehabilitation of Physically Handicapped Adults Living in Foster Homes

Social Work Intervention in the Adaptation to Family Environment

Howard D. Young, Ph.D.
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Marygold V. Nash, D.S.W.
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October 1966

INDEPENDENT LIVING

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Social Work Intervention in the Adaptation to Family Environment

A Final Report to

the Vocational Rehabilitation Administration

for Research Grant No. RD 808p

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1966

PREFACE

The Independent Living Project was co-sponsored by the Vocational Rehabilitation Administration and the New York Service for Orthopedically Handicapped during the five-year period September 1, 1961 to August 31, 1966. The project demonstrated that foster homes can be found for physically handicapped adults and that a foster home is a suitable step between institutional life (or unsatisfactory home life) and greater independence in community living.

Seventy-eight adults were moved into foster homes during the first four "placement years" of the project. (This is a greater number than appears in the research tables because particular preplacement data were not available on the few who were already in homes when the permanent research director jointed the staff.)

Contrary to many predictions, there were no accidents in the homes, such as falling or being burned, and there was a surprisingly low incidence of hospitalizations. The criteria of acceptable clients were sometimes ignored. Clients were placed who had progressive medical problems or severe personality disturbances and who were older than the stated age limit. An attempt was made to show that foster homes could be found even for those who were seemingly less attractive to the general community.

The clients received casework, family and group counseling. It was recognized that in many situations progress was difficult to measure. For certain clients, merely remaining in the community at all was progress. Sometimes it takes a lot of running to stay in the same spot!

The service staff consisted of a supervisor and full-time and part-time (two days to four days per week) graduate caseworkers who together made up the time of five full-time workers, one of whom acted as the homefinder. This number was maintained until the fifth year of the project when new placements and homefinding were terminated. During the fifth year, two social work assistants replaced caseworkers and worked successfully in maintaining clients in placement. The project offered field work training to three graduate casework students from Columbia University School of Social Work.

The research staff consisted of a director and three part-time assistants who were college students.

"Living with research" has been found difficult in many "action" settings where service methods are evolving. Herman and Sadofsky reported that respondents in their study "were quite clear about the tense working relationships that existed

between action and research personnel."[1] That study also confirmed that "Evaluation is likely to be feared or resented by operating personnel."[2]

Frequent discussions between service and research personnel, the research director's attendance at the more formal casework meetings regarding problems in selection, placement and maintaining placements--and, doubtless, the mature attitude of staff--all combined in this project to reduce the expected clash of interests to an unusually harmonious working relationship. The service staff were willing to have their work evaluated. There was no directive pressure on the outcome. The caseworkers, who found the task both complex and fascinating, developed a conviction that the job was worth doing sincerely at the highest point of ability, and that it was important to study the great variety of needs of the client and how these could be met. They were neither intimidated nor annoyed by the demands of the research. They felt that the research staff made a successful effort to understand their methods and intent. All records, even the day sheets, listing the smallest activity, were open to the research staff.

It was found that the project cost $211 per client-month of foster home placement. This was the cost of the entire project operation including the $50 per month supplementation to the Department of Welfare budget of $150 per month for board and room. (The foster family received $200 per month.) The Department of Welfare also gave an average of $25 per month for expenses such as personal needs and transportation. This means that the total cost of keeping a disabled person in a foster home was $211 + $175 = $386 per client-month--just under one-half the average cost of a patient-month in 1965 in the New York City hospitals giving chronic care. It is obvious that without the research component, the service cost would have been even less.

The increased opportunities for human development, supported so strongly by the marked financial saving, should commend to community planners everywhere this alternative to institutional existence.

M.V. Nash

New York
October 1966

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[1] Melvin Herman and Stanley Sadofsky, Youth-Work Programs: Problems of Planning and Operation (New York: New York University, 1966), p. 177.

[2] Ibid., p. 181.

ACKNOWLEDGMENTS

The first indebtedness is to Dr. Melvin Herman who, as Executive Director of the agency, planned this project and brought it through the first difficult year successfully.

The second acknowledgment is the appreciation of the cooperation of the community agencies with whom we worked most frequently: the Social Service Departments of the hospitals which are listed in the text; the Department of Welfare, New York City; the Nassau County Department of Welfare; the Division of Vocational Rehabilitation; and the United Cerebral Palsy of New York City, Inc.

The third recognition of assistance goes to the Professional Advisory Committee who took time to hear the many problems and to give encouragement and direction. They were: Dr. Lester A. Gelb, Director of Out-Patient Psychiatric Services, Department of Psychiatry, Maimonides Hospital of Brooklyn; Dr. Bruce Grynbaum, Director of Rehabilitation Medicine, Bellevue Medical Center; Dr. James G. Haughton, First Deputy Health Services Administrator, New York City Department of Welfare; Dr. Edith Kristeller, Chief of Physical Medicine and Rehabilitation, Veterans Administration Hospital; Miss Janet Pinner, Director of Special Placement Services, New York State Employment Service; Miss Lillian Richards, Director, Social Service, New York City Department of Hospitals; and Dr. John Unterecker, Director of Physical Medicine and Rehabilitation, Roosevelt Hospital.

A special expression of gratitude goes to the staff members who made such a valuable contribution to the understanding of the problems of disabled adults; to Dr. Margaret Nix who conducted a reading class for some of the project clients and who was so helpful in the editing of the report; and to Mrs. Jane Palese who typed the final copy.

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Lillian Slann, M.S.W. - Caseworker	1962-65
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#Part-time employee.

The study was co-sponsored by the agency and a grant from the Vocational Rehabilitation Administration. We are grateful for this generous support. We also wish to thank the United Cerebral Palsy of New York City, Inc., for help with the cost of transportation.

INTRODUCTION

The first two chapters of the report describe the various stages in the research-demonstration program and give specific information which is intended to be helpful to those who are engaged in related work. Inasmuch as this experimental project may be adopted in some form by others, it was felt that a detailed report of the entire project would allow for the rejection of those unnecessary and possibly harmful aspects of the program and the introduction of beneficial modifications.

The next four chapters focus on the methods that were used to evaluate the important features of the program and to ascertain whether the main objectives were reached. This is the research-analytical section in which the major reasons for the failures and successes in the program are analyzed in detail.

Describing the comprehensive role of the social worker, Chapter VII is a report of the most unique aspect of the study, the social worker intervention that was required in the multitude of environmental details that arose and in the range of interpersonal relationships from the simplest to the most complex.

Chapter VIII gives the summary of the findings, the conclusions and the recommendations.

Technical data and expanded comments are included in the Appendix for readers who are interested in further details about particular aspects of the project.

INDEPENDENT LIVING PROGRAM PROCESS

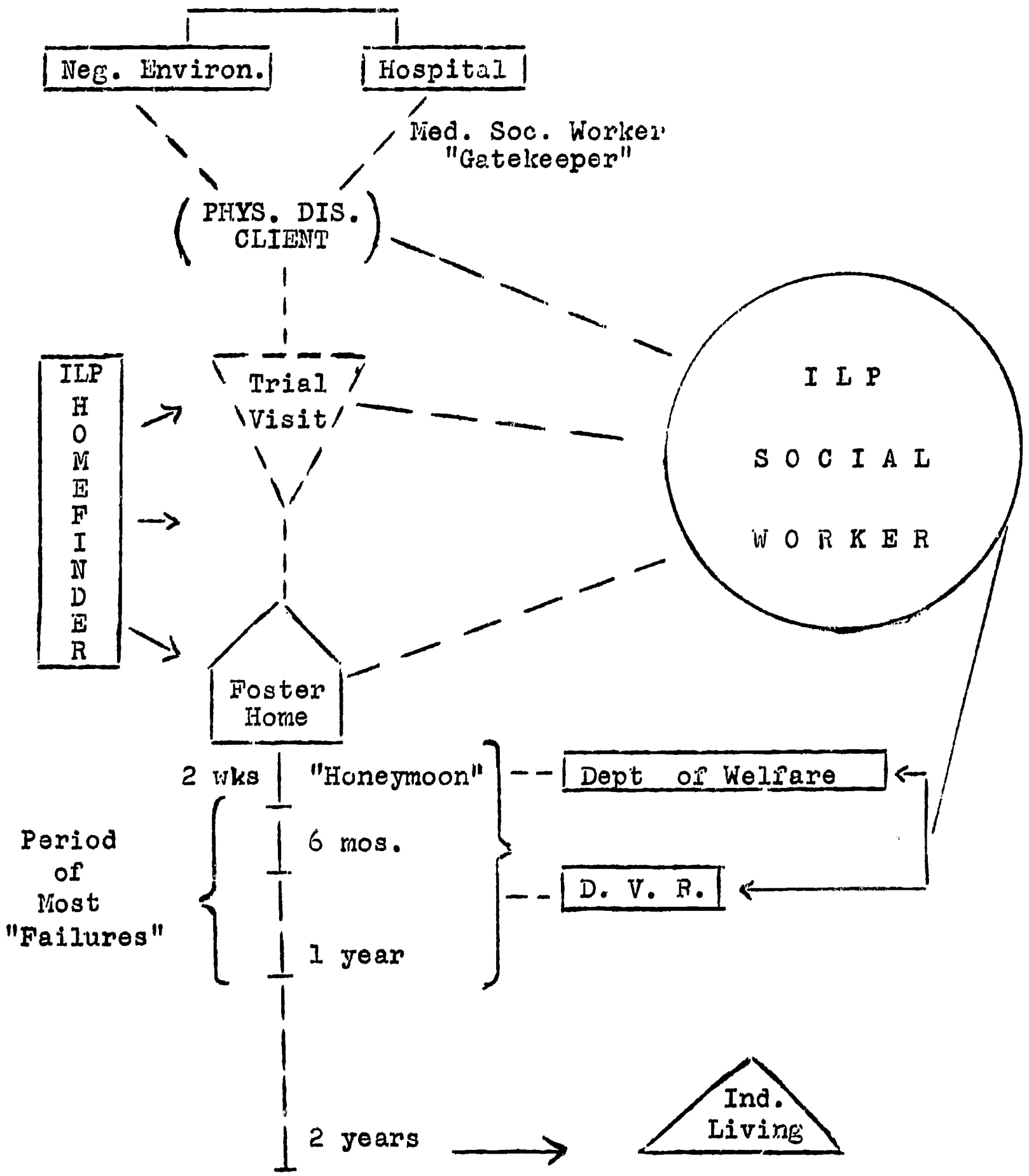


TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF CHARTS

CHAPTER I

DESCRIPTION OF THE PROGRAM

One of the programs of the New York Service For Orthopedically Handicapped is a summer resident camp for adults. Many of these campers who were able to take care of their own personal needs were known to be living in institutions during the fifty weeks of the year between camp sessions. The agency investigated possibilities for a solution to such an unsuitable living arrangement and produced this project to demonstrate one answer to the important question: Where can I live?

I. BACKGROUND AND OBJECTIVES OF THE STUDY

The basic objective of the Independent Living Project (ILP) was: "to test the feasibility of a foster home program as an alternative to unnecessary in-patient care of adults with orthopedic disability."[1] To achieve this objective, a research-demonstration project was established, and focused on two groups of physically disabled young adults for whom facilities for successful community living were hitherto unavailable.

The first group in the project consisted of persons who were occupying beds in various institutions and who could not be discharged despite the fact that they no longer required hospitalization. Numerous studies have indicated that there

were many disabled who fell into this category.[2]

The second group consisted of persons who were living in the community under such unsatisfactory circumstances that they were expected eventually to deteriorate and require some type of institutional care. Many physically handicapped in this large urban community were living at subsistence level in run-down hotels and rooming houses or with their families, who were destructive in their attitudes and behavior to the handicapped person. Although this group was less visible than the other, it was felt their needs were similar to those of the institutionalized group.

Residential Care Resource

For both of these groups the major problem appeared to be the need for some type of residential setting. An examination of the various possibilities indicated that a special residential setting outside of the community was not feasible for many of the more severely handicapped, particularly those with cerebral palsy.[3] An analysis of the type of environment that might be most beneficial to these potential clients led to consideration of the use of "family-type" environments. The principal problem of many of the handicapped adults was the need for both personal care and an environment that would overcome the isolation in which so many of the disabled find themselves. Further, it was felt that many of the disabled needed the emotional security that could be provided by integration into family life. In many cases it was anticipated that by virtue of its own place in the community, a family could forge the social links for the disabled adult and thereby assist in his integration into community activities.

The original project proposal also anticipated that the program would incorporate the following desirable results:

"It would reduce hospital use and stay:- We

believe that the services which we propose to provide will greatly reduce first admissions, readmissions, and average length of stay in costly hospital facilities. With respect to first admissions, many physically handicapped persons who have no major unmet medical needs are nevertheless compelled, for lack of a suitable alternative living arrangement, to accept hospital care. Similarly, patients are often readmitted to hospitals who have deteriorated physically because of inadequate living arrangements. The program would also reduce the average length of stay in hospital facilities, which is now excessive partly because appropriate living arrangements to which patients can be discharged are not available.

"It would make it possible for the patient to use existing community rehabilitation services: Despite their great financial cost to the community, the benefits of physical rehabilitation programs are wasted if patients cannot be discharged to the community where they then can make full use of such services as vocational evaluation and training.

"It would reduce the costs of patient care:- It has been demonstrated in programs such as "home medical care" that it is generally far less expensive to maintain patients in the community than in hospitals. By increasing the likelihood of patient maintenance in the community, this program will help to reduce the cost of patient care.

"It could be provided by existing service agencies:- No new capital facilities or service organization are required in order to implement this proposal widely. Once its viability has been demonstrated, this new pattern of service could be carried out by existing public and private agencies.

"It is applicable to diverse geographic areas:- The pattern of service which we propose need not be limited to areas where large, expensive, consolidated facilities exist or where large numbers of patients are concentrated. This service can be provided in small towns and rural areas just as well as in metropolitan areas. Wherever community services to the handicapped are offered, this program can also be offered."

Social Work Intervention

The placement of the clients in foster family settings was to be made by trained social workers. Although the role of the social workers was not described explicitly in the objectives, their assistance to and intervention for the client was an important feature of the program and presented another major factor to be considered in the evaluation.

The program also undertook to demonstrate the effects of foster-home[4] care for disabled clients. They were to receive the on-going services of trained social workers who would assist them in adjusting to and making progress in the community. In a number of cases, it was expected that some of the clients would use the foster homes as a temporary setting and then moved to another type of residential setting.

Comments on Objectives and Structure of the Project

The current research director did not enter the program until the beginning of its second year (such are the vagaries of research-demonstration projects). Although the objectives of the program were clearly delineated, little time was given to provide for more specific details concerning the type of population available and the types of homes available. The collection of some simplified data would have immediately clarified some of the objectives and allowed for a more realistic evaluation of the program. It became obvious that many were suffering from severe personality disorders. Although they should have been excluded from the program under the original criteria, we found later that notonly was this the population that needed the greatest assistance, but that it also constituted the majority of the disabled population. An analysis of types of homes would also have indicated the wide range of possibilities available and allowed for the development of objectives that were not predicated solely on a "family" type of environment.

Basically, in looking back at the initial stages of the project, it becomes apparent that without an initial collection of data regarding the populations to be served, and the type of service or placement they are to receive, a program cannot provide as much meaningful information as it otherwise could. (Note: Further discussion of this problem and suggestions will be found in the section on methodology and evaluation.)

Brief Overview of the Implementation of the Program

At the outset, hospitalized clients were generally recruited, or they volunteered for the program on the basis of

information that was given to them by their social workers. Other clients, who came from unsuitable environments in the community, learned about the program through other agencies with which they had come in contact, or through their participation in the agency's camp for the disabled. The clients were seen by an intake worker who interviewed most of the clients before they actually entered the program. The intake worker filled out forms giving information about the client's general physical condition, needs and personality traits. This intake worker would also discuss the client's background with the social workers in the various hospitals or with others who might have information about him. In general, once the client passed this first screening, he was then accepted into the program and assigned to a social worker.

In the initial stages of the program, a large number of homes were obtained via mass media publicity. The home-finder visited the various families that were interested in becoming foster families, reported in detail on the physical setting of the home, and described the personality of the families, including any problems that might be encountered in placing clients in that particular home.

The social worker who was assigned to the client screened the various homes that were available and, after visiting some of the families, decided on the most suitable home. At this stage the social worker had met with the client a number of times at the institution or in other settings including the agency's office and had discussed his problems and needs. The clients filled out various forms for the research division and completed a number of tests. The families were also given forms and tests to complete and in some cases were interviewed by one of the members of the research division.

After the home was selected, the social worker arranged for a trial visit. The client stayed with the family for two or three days (usually a weekend), after which time the placement was discussed with both parties and evaluated. In many cases, if it was possible, the client remained with the family and arrangements were made for a permanent placement.

The social worker was also available at all times to both the client and the family for any problems that might arise and kept in close touch with the client and the foster family (generally by telephone) during the initial period of placement. At the same time, arrangements were made for the client to see counselors in various other agencies--the Division of Vocational Rehabilitation and agencies sponsoring workshops or recreational programs. Plans for the clients were discussed with them during this initial period and arrangements were made for the implementation of those plans.

In some cases, physical modifications of the homes were made, the cost generally being paid by the New York Service For Orthopedically Handicapped (NYSOH). The foster families received $175 per month at the beginning of the program and later $200 per month. Fifty dollars of this amount was paid by NYSOH and the greater part by the Department of Welfare. When the client became employed, he contributed to the budget according to his ability to pay.

When severe problems developed in any of the environments in which the disabled clients were placed, the social worker made arrangements for their removal and for their subsequent placement in whatever particular institution or alternate environment available at the time. If absolutely necessary, the client was returned to a hospital or was placed in a nursing home. In some cases, the clients withdrew and made arrangements on their own.

Information about the clients' adjustment and progress in the community was continuously compiled by the research division through a number of inventories and questionnaires that were filled out periodically or for specific purposes by the social workers. They also kept case records of all of the meetings between themselves, the client and the foster family, and the issues that were discussed or problems raised were set down in great detail. Frequent discussions were held between the members of the research division and the social workers in order to obtain additional information about the general processes involved, and to feed back to the social workers any information that may have been obtained by the research division.

II. MAJOR SOURCES OF REFERRAL TO THE ILP

The majority of referrals to the ILP were from institutions or agencies which served in some form the needs of the disabled (see Table 1.1, page 7).

Recruiting Clients from Institutions

Three channels for recruiting clients from institutions will be discussed here, together with the obstacles that may present themselves.

1. Formal channels of communication. At the start of the project, the directors of the various institutions for the chronically ill and the

TABLE 1.1

DISTRIBUTION OF THE PLACED AND THE NON-PLACED CLIENTS ACCORDING TO SOURCE OF REFERRAL

Source	P	N-P
Voluntary Hospitals	21	39
Columbia-Presbyterian	3	4
Hospital for Joint Diseases	1	2
Hospital for Special Surgery	2	3
Instit. of Physical Med. & Rehab.	3	8
Jewish Chronic Diseases	6	6
Maimonides	0	2
Montefiore	4	2
Mount Sinai	2	0
New York	0	7
NYU Medical Center	0	2
St. Vincent's Hosp. & Med. Cntr. NY	0	3
State Hospitals	6	2
Kings Park	1	0
New York State Rehabilitation	2	1
Pilgrim	3	0
Rockland	0	1
Federal Hospital	4	5
Veterans Admn.	4	5
Vocational Training	8	13
Div. of Vocational Rehabilitation	1	2
Federation of the Handicapped	1	2
Instit. for Crippled & Disabled	6	5
UCP - Nassau	0	3
Youth Consultation Service	0	1
City Hospitals	19	26
Bellevue	4	12
Bird S. Coler	7	5
Elmhurst	0	1
Goldwater Memorial	1	2
Harlem	0	1
Jacobi	1	1
Kings County	4	2
Lincoln	0	1
Metropolitan	2	0
Queens General	0	1
Miscellaneous	16	22
Catholic Charities	1	1
Community Service, Westchester	1	0
Dept. of Fam. & Child Welfare, W.chester	1	0
Dept. of Welfare	1	1
East Tremont YM-YWHA	0	1
Family Physician	0	1
Girls Terminal Court	0	1
Jewish Fam. Services	0	1
Multiple Sclerosis Society	1	0
N.Y. Ser. for New Americans, Inc.	0	1
N.Y. State Educ.Dept.	1	0
Self-referral	5	3
Non-professional	2	10
United Cerebral Palsy of N.Y. City	3	2

Placed; total N = 74

Non-placed; total N = 107

Director of the NYSOH met to discuss the implementation of the ILP. The procedures and policies of the agency were outlined, coupled with the request that the institutions establish policy designed to assist the disabled who were interested in participating in the program. Frequent visits were made to the institutions, and the program was presented and discussed at these meetings, particularly with the medical social workers.

It soon became obvious that the upper echelon administration did not have and could not develop a policy for expediting the release of clients who no longer needed custodial care and who would be interested in participating in the program. The structure of the institution and the general procedures extant were not modified to allow for the movement of any substantial number of patients from the hospitals.

An analysis of the obstacles on this level, based on the opinions of those who worked directly with the institutions, indicated that there was no sense of urgency about moving the clients into the community, and some skepticism about the ability of the more severely disabled once placed, to remain in the community. Perhaps one of the factors blocking greater participation was the need for the hospital to agree to re-accept the client should his placement in the community prove unsatisfactory.

It is possible that many of the obstacles to the release of a larger number of patients were the result of complicated bureaucratic procedures. In a recent study, the authors noted that one of the reasons for the "lon -stay" of the disabled in the hospitals was the "lack of coordinated professional teamwork such as an organized review of the cases, written progress notes and joint planning to meet patients' needs by physicians, nurses and social workers."[4] In another rehabilitation study, the researchers found that this slowdown policy was adopted:

> "a) to keep administrative and treatment staffs from being overworked.
> b) to make sure none of the inmates is given anything he is not entitled to.
>
> Both of these things slow up the process of making decisions and taking action."[5]

In a number of institutions it is this lack of coordination that interferes with the discharge of the disabled patient. Researchers also find that the staff's refusal to take a chance holds back many clients. Authors have noted further that:

> "Staffs of all these institutions tend to be conservative and when in doubt, hold on to the patient for a longer period. Nothing gets them into more difficulty than taking a chance with a borderline case and failing."[5]

2. The role of the "gate-keeper"--the medical social worker. The medical social worker (MSW) in most of the institutions served as the "gate-keeper" for many of the clients in that she generally was in a position either to expedite or to delay the discharge of the patient. It was her responsibility to provide for the "environmental service,"[6] that is, to arrange for the client's needs in the community and to make the necessary arrangements with relatives and agencies.

   The success of the client-recruitment stage and participation in the ILP was dependent to a great extent on the involvement of the MSW. A number of factors, however, frequently interfered with the MSW's ability or interest in releasing the clients. These were:

   a) Lack of time. The caseloads of most of the MSW's were heavy and did not leave them enough time to become involved with larger numbers of potential dischargees who might be eligible for the program. Thus the tendency of many of the MSW's was not to undertake any additional cases, or motivate others to leave the institution.

   b) Role-conflict. The role of the MSW has generally been viewed as one in which she assists the client in his transition to the community by providing for the arrangements in the community. It is in this area that she is generally viewed by the other professionals in the hospital as having her "competence." The unusual role played by the project SW's in assisting the client as soon as he had left the institution, and even while in the institution, resulted in

interference with her role as seen by the MSW. The MSW might view her role as directly related to these areas and feel that it should be under her "control" or jurisdiction. In addition to the "control factor," the MSW may derive a good deal of personal satisfaction from being the center person in the life of the patient, moving him to a higher level of independence and functioning, and thereby gaining a certain degree of gratification. Evidence for this possible conflict of interest arose in a number of occasions, and in some cases, the client expressed the desire to go back to the hospital to discuss certain decisions with his MSW.

c) High turnover rate and lack of continuity. There is high turnover rate among the MSW's in the institution, making it difficult for other professionals to establish a satisfactory personal relationship with the MSW who is a key worker in the discharge process.

d) Lack of confidence in MSW by clients. A key person, in this case the MSW or "gatekeeper," who can determine to a great extent the patients to discharge but who lacks the confidence of the patients or is in other ways unapproachable, presents serious problems in the recruitment of clients. In one established case, a MSW was the major block to the discharge of a large number of patients who were interested in ILP.

e) Negative views of the MSW. MSWs form their opinions as to which disabled clients could adjust to community living, generally on the basis of many years of professional experience. However, there are frequently innovations with which the MSW is not familiar which allow even the more severely handicapped to adjust to community living. In some of the cases in this program, the MSW had to be persuaded to become involved in the discharge of a severely disabled client. (After the client had succeeded in the community, the MSW began to urge others in the institution to move out to the community.)

f) Lack of information. The MSWs were not always familiar with the details of the ILP and were not able to convey accurate information to the clients.

Although there were problem areas as outlined above, there were also a number of MSWs who went out of their way to bring the ILP to the attention of the patients and assist in preparing them for discharge. In some cases, the MSW took the initiative in bringing the potential client to the attention of the medical staff and provided the necessary coordination to obtain the maximum rehabilitation for the patient.

3. Casefinder--Intermediary agent. A casefinder from the ILP frequently visited many of the institutions to interview patients, acquaint the staffs with the program and establish relations with the MSW. This procedure was helpful and allowed for a direct implementation of the program, but was mainly dependent upon the element of personal contact.

III. THE DISABLED CLIENT AND THE INSTITUTION

As most of the referrals to the project were from institutional settings, it is important to discuss the effects of institutionalization on the client and the motivation that is necessary for him to consider more independent living.

Effects of Institutionalization

Although hosts of studies have pointed to the detrimental effects of institutionalization on the personalities of the inmates, particularly institutions for the mentally ill, application of these findings with the project population may not be valid. For a group of severely disabled persons, it is possible that there are positive attributes to an institutional environment, making it superior to living in the community. Edgerton & Sabagh,[7] in applying Goffman's[8] conception of institutionalizations to the mental deficiency institution, suggest that the "mortifications of self" for the high level

defective may be fewer within the institution than in the outside environment, and that certain "aggrandizements" of the self are available in the hospital. Such aggrandizements include the presence of clearly inferior low-grades with whom they can compare themselves favorably, their far greater social success within the institution, and mutual support for face-saving rationales concerning their presence there. These are all factors that could pertain to the severely disabled. The environment of the hospital offers the physically disabled far fewer anxiety-provoking conditions. Services are quickly available and accommodations are made to take their special needs into account. Many institutions have some form of leisure-time activities for their patients and they have an opportunity to participate in a variety of activities.

Although it was not feasible to compare a matched group of subjects who moved from the hospital to the community with a similar group who remained behind, it was possible to accumulate information from the clients which gave some comparative data. In spite of the above-mentioned advantages of institutional living, their views strongly supported the superiority of community living.

In the area of vocational advances, a comparison was not even called for inasmuch as only clients who were moved into the community could avail themselves of the opportunity for vocational training and employment.

Motivating the Disabled Patient to Move to a New Environment

One of the major questions at the outset of the program was whether disabled persons who had spent a considerable length of time in an institution would be willing to move from the institution to the community, a far less sheltered setting. This was closely connected to the question as to whether community living was superior to institutional living for the disabled patients.

Although the project was not designed to compare the relative movement of the patients who left the institution with those who remained, information obtained from our clients and from the reports of other researchers (relative to progress in a number of areas) provide us with some insight into the advantages of community living.

The hospital patient was motivated by a description of possible life in a foster home and by the assurance that he could return to the hospital setting if he did not want to remain in the community.

Major Reasons Cited by Clients for Wanting to Leave the Institutions

The project clients completed information schedules in which they were requested to compare their current mode of living with that of life in the institution and to indicate the differences. In this schedule, many of the clients listed the reasons why they did not enjoy life in the institution. The factors listed below have also been mentioned by others in a recent study. The researchers found in their study of a rehabilitation hospital that the "patients live much of their lives alone. The patient in a large hospital surrounded by people day and night and sometimes suffer from being unable to get away from all these people with whom he has relatively little in common except his disability, his poverty and his helplessness, and he may view the staff as people who are often as much his oppressors as his therapists and caretakers."[9]

An analysis of the major factors listed by the clients as being negative aspects of living in a hospital for the chronically ill or a rehabilitation institution was performed. The following are central themes in their reports.

1. Regimentation. Patients had to follow a regular routine and live in accordance with a set time schedule. This interference with the right of adults to make the decisions and enjoy the freedom of deciding, for example, when to eat or at what time to go to bed, was most disliked by the patients. Inasmuch as these were physically handicapped adults it established a pattern of dependency or played into an already existing one.

2. Absence of responsibility. Clients complained about not having the right to make decisions and confront some of the major problems in life. One client commented, "In the hospital everything is handed to you. You become lazy."

3. Boredom. The same routine followed most of the time was, of course, the basis for the complaints about being bored. Although many hospitals have activities, apparently there is a sense of confinement which plays into this pattern of feeling. Meeting constantly with the same persons intensifies this feeling, particularly when many of the same experiences are shared.

4. Sense of being divorced from the mainstream of life.

   A number of clients complained that they felt life

was passing them by. As one noted, "After being there (in the institution) for a length of time you feel as though you are missing everything that is going on in the outside world."

5. Absence of opportunity for work on the outside. Patients could not, while in the institution, get a job or engage in an area of work they might enjoy. There were obvious limitations to their earning power and there was a feeling on the part of some that they could not earn as much as they were capable of earning.

Other disadvantages in institutional living that were mentioned were:

1. In the community you can socialize with people of your own age.
2. You have a choice of what to eat and types of clothes to wear.
3. Your own items belong to you, such as the television and telephone and possessions do not "disappear."
4. You can make your own arrangements, such as being out late.
5. You can go shopping and for walks whenever you please.

The clients who were placed in homes were asked to comment on their typical daily routines and way of life as compared with life in the institution. Here are the comments of two such clients and also those of a client before placement.

Case 1. "My everyday life here is quite different from everyday life in the hospital. In the hospital it's the same routine every day. You don't really feel you have any responsibility in the hospital and after being there for a length of time, you feel as though you are missing everything that is going on in the outside world. Since I am working, it seems everything has changed. My job means very much to me. It gives you a feeling of security and also have responsibility. There are things you must do for yourself because you know if you don't do them no one else will. Where in a hospital you know there is always someone to help you. Another thing I have found out since I am working is: I have learned to do many things for myself, which I thought to be impossible. I will also say since I am out of the hospital

and working, my outlook on life is completely different. I now feel I have a bright future ahead of me."

Case 2. Severely handicapped in an institution for about 25 years

"Since I had left the hospital I had found a new life for myself in a foster home in which I am very thankful to the New York Service in helping me out--a new world of severely brightness against hospital life. First of all I get up every day by going to the Brownsville Center to learn how to be a housewife to my husband. I start to get up in the morning at six o'clock to get ready for the driver to pick me up at the regular time. When I come back home I eat my supper at six o'clock. After supper, I wait for a telephone call from my future husband. And later in the evening, I watch TV for recreation until eleven o'clock. That's everyday routine. The weekends I go out with my future husband shopping or go to the movies. In the hospital I used to have the same old routine every day. There wasn't any activity to talk about. It was very boring. We had to be under their rules and regulations. You had to be in bed at a certain time which I used to hate. I see new people every day. By seeing these people, I have met nice friends. I am very happy with that."

Case 3. Potential client still in hospital

"I'm still in hospital waiting to get out. I hope it's soon. I can't stand this hospital anymore. I want to do so many things such as going back to school and going to clubs but I cannot do this while I'm in here. I hope I will be out of here by the end of August. I'm very depressed. I know it takes a long time to find a home but the things that go on here are unbearable and it gets worse every day."

IV. CHARACTERISTICS OF PLACED AND NON-PLACED REFERRALS TO THE ILP

As some of the clients who were referred did in fact make a successful adjustment in a foster home and others found it impossible to take the steps of moving into this setting, it was thought to be important to compare the characteristics

of these two groups and suggest some reasons for the different behavior patterns.

Clients in the ILP Who Originated in an Institution

Hospitals for the chronically ill or rehabilitation hospitals referred 50 per cent of the clients (thirty-seven) in the ILP. Some characteristics of this group will be given in Table 1.2 (page 17).

These clients had been institutionalized for varying lengths of time, some of them for most of their lifetime. Their willingness to leave the institution indicates that long-term institutionalized clients should not be excluded from this type of program.

A large number of clients were cerebral palsied, although there were a variety of other types of disabilities. Approximately 35 per cent of the group was wheelchair dependent, that is, unable to ambulate, and about the same number required some assistance in personal care.

As can be seen from the figures in Table II about 60 per cent of the patients in the institution were not in need of any type of assistance in personal care and were ambulatory. Thus their confinement in the institution must have been based solely on the inability of the institution to make plans for some form of placement in the community.

The group was about evenly divided between those who had their disability from birth or as a young child, and those who acquired the disability later on, after adolescence. The ages of the clients on entering the program were quite varied although about 80 per cent were below 50. Less than 50 per cent of the clients had graduated from high school and even those who had were not really able to read or write at a high school level. The educational deprivation of the group was great except for a few who were unique in the group and who had acquired their handicap much later in life.

The male outnumber the females in the program. A most noticeable characteristic of the population was the small number of Negroes that were in the program, particularly Negro males. Although the basic reasons for the small number of members in this group were not determined, a few suggestions can be offered that might account for this factor.

1. In some hospitals there were Negro women who served as aides or nurses. Apparently, when they left the institution, they set up boarding homes for a number of disabled Negro clients and thus

TABLE 1.2

CHARACTERISTICS BY PER CENT OF PLACED CLIENTS
WHO CAME FROM INSTITUTIONS
(N - 37 = 100 per cent)

Characteristic	Per cent	Characteristic	Per cent
No. of years in institution		**Age**	
6 mos. - 1 year	41	Under 25 years	22
1 year - 2 years	16	25 - 35 "	24
2 " - 5 "	19	36 - 50	30
5 " - 10 "	5	51 - 60 "	24
10 years or more	19		
		Sex	
Disabling condition		Male	59
Poliomyelitis	13	Female	41
Cerebral Palsy	27		
Multiple Sclerosis	3	**Age at onset**	
Other Neural Disorders	18	Birth	30
Arth. & joint diseases	8	Under 5 years	8
Spinal defects	16	5 - 10 years	8
Amputation	8	10 - 15 "	3
Paraplegia (non-polio)	5	15 - 21 "	8
		Over 21 "	43
Prognosis		**Mobility**	
Improvement possible	11	Wheelchair dependent	35
Stable maintenance	73	Ambulatory dependent	33
Slow deterioration	16	" independent	32
Fast "	0		
Personal care		**Education**	
Eating - Independent	76	College graduate	3
Dependent	24	Some College	5
Dressing - Independent	70	High School graduate	32
Dependent	30	Some High School	14
Toileting- Independent	65	Completed Grade School	35
Dependent	35	Some Grade School	11
Bathing - Independent	54		
Dependent	46		

served as their own community placement service. It was not possible to evaluate this type of placement; however, it is unfortunate that there were many applicants who did not participate in the ILP as there were many Negro homes available (see later section on foster homes).

2. The Negroes' attitude towards private social agencies or agencies in general, many have speculated, is not a positive one.[10] There was probably great reluctance on the part of many potential Negro clients to volunteer for a program that would bring them into such close contact with another social work agency.

3. The attitude of the Negro family or the general Negro community is such that many more Negro families appear to be willing to keep a handicapped member of the family at home. In many cases, these families live under such extreme hardship that the presence of another person to take care of does not seem to add disproportionately to the burden, and the money that the disabled person receives from welfare or another source also apparently assists the family or relatives in supplementing their meager income.

   An additional factor appears to be that the attitude of the Negro family (and one would assume Negroes in general) differs according to the severity of the disability. A researcher in his study of the critical experiences in the rehabilitation of the physically disabled found that "among the Low (lower class) Negroes and the Low Whites, it was the most able and most rehabilitated who, reported their families, regarded them as a burden; and the least able and least rehabilitated who, reported their families, were kinder to them since they became disabled. Among the Middle (class) Negroes and Middle (class) Whites the relationship is reversed, with the families of the most disabled and least rehabilitated persons regarding them as a burden...."[11]

   Inasmuch as most of the Negroes would fall into membership in the Lower Socio-economic class, it is understandable why so few Negroes were in the program in the early stages.

Reasons for the Lack of Participation in the ILP of a Comparable Group of Clients Still Institutionalized

In order to determine the major reasons for the lack of

interest in this project of handicapped clients who are eligible and able to live outside of the institutions, a group of patients, currently hospitalized, was interviewed in depth. The purpose was to obtain information about their personalities and their reasons for desiring to remain in the institution, and to compare them with those clients who left the institution and became part of the project. The interviewer was a trained psychologist who was familiar with many of the subjects and was in a position to elicit honest and meaningful responses.

Unfortunately, we learned that this type of comparison could not be made because most of the patients had not heard of the ILP, and in any case, a majority also indicated that they would prefer living on the outside if arrangements could be made for them. When it was suggested that they apply to the appropriate authorities, the patients refused because they found the required hospital discharge procedures distasteful.

Eight hospitalized patients were interviewed and Table 1.3 (below) shows some of their characteristics.

TABLE 1.3

CHARACTERISTICS OF PATIENTS IN A CONTRAST GROUP
(N = 8)

Characteristic	Number	Characteristic	Number
No. of years in institution		Age	
1 - 5 years	1	18 - 25 years	3
10 - 15 "	5	26 - 30 "	2
26 - 30 "	2	36 - 45 "	2
Disabling Condition		Sex	
Cerebral Palsy	5	Male	7
Muscular Dystrophy	3	Female	1
Age at Onset		Mobility	
Birth	5	All clients were wheelchair dependent	
1 - 5 years	3		

This contrast population is similar in age and type of disability to the many that participated in the ILP. Although all of them are wheelchair-dependent, an examination of the type of assistance they require indicates that they do not need an excessive amount of aid by others. More than half of these patients at present can look forward to continued institutionalization for the remainder of their lives.

Some of those concerned with the welfare of this type of population contended that their lifetime of institutionalization has left them too fearful to attempt to live in the community but an analysis of length of hospitalization figures for our population would indicate that this is not the case. The final results indicate that this group has the ability to adapt to community living.

Although the lack of information about the ILP program was a major reason given by the patients for not participating in the program, and procedural obstacles as the reason for their refusal to apply when they heard of the program, there may be another factor that played a role in their hesitancy. As indicated above, the lifetime institutionalization factor does not appear to be the salient one. However, it was noted that all of the patients had a family who visited weekly and who were in close contact with them. Many of the clients expressed the view that they did not have to live with or find a "substitute" family because they had their own. For the clients, in effect, accepting a "substitute" family was tantamount to being rejected by one's own family, and provoked a good deal of anxiety. It was therefore possible that many of the clients could not accept the program because of the underlying feelings of rejection and guilt aroused by the idea of moving to another "family."

Clients in the ILP Who Came From Unsuitable Environments in the Community

One of the "target populations" for inclusion in the project were orthopedically disabled clients who were living in unsuitable environments in the community. It was anticipated that there were many disabled who were living in hotels, boarding homes or in family situations that were detrimental to their physical and mental health.

The definition of "unsuitable environment" was left vague at the outset. It was expected that each case would have to be judged on the merits of the prevailing conditions. An example found later was a room in a deteriorated hotel, described by a project caseworker as "an enlarged telephone booth."

A careful analysis of the features of the "unsuitable

environment" of the clients in the ILP showed the following reasons given in Table 1.4 (below) for accepting them for placement.

TABLE 1.4

REASONS BY PER CENT FOR CLASSIFICATION OF CLIENTS FROM "UNSUITABLE ENVIRONMENT" (N - 37 = 100 per cent)

Reason	Per cent
Parental inadequacies	
Parent too ill to care for client	08
Parent and family reject clients	38
Disorganized family	05
Living Facilities Inadequate	
Clients living in hotels, inadequate apartments, rooming or boarding houses	32
Clients living in temporary quarters	16

A distribution of the characteristics of the thirty-seven clients who were living in unsuitable environments before placement will be found in Table 1.5 (page 22).

In a number of cases the families of the clients requested that the agency find a suitable place for the client who might otherwise have to be institutionalized. Another group of clients were living in hotels filled with degenerates, prostitutes and drug addicts. The atmosphere was one that was most conducive to engendering deviate behavior of an extreme sort with possible addiction to narcotics and other drugs. On the basis of knowledge of those who have been recommended to the program and of the environment from which they came, it could be reliably estimated that there are some hundreds living in this type of unsuitable environment. Many of them come from a lower socio-economic class and insofar as their living arrangements are involved, they are similar to those of the non-disabled in that particular stratum of society.

TABLE 1.5

CHARACTERISTICS BY PER CENT OF CLIENTS
FROM UNSUITABLE COMMUNITY ENVIRONMENTS
(N - 37 = 100 per cent)

Characteristic	Per cent	Characteristic	Per cent
Disabling condition		**Age**	
Poliomyelitis	3	Under 25 years	35
Cerebral Palsy	51	25 - 35 "	30
Multiple Sclerosis	11	36 - 50 "	30
Other Neural Disorders	8	51 - 60 "	5
Arthritis and joint diseases	8	**Sex**	
Spinal Defects	14	Male	49
Amputation	2	Female	51
Paraplegia (non-polio)	3	**Age of onset of Disability**	
Prognosis		Birth	59
Improvement possible	78	Under 5 years	3
Stable maintenance	14	5 - 10 years	3
Slow deterioration	3	10 - 15 "	0
Fast "		15 - 21 "	8
		over 21 "	27
Personal care		**Mobility**	
Eating - Independent	70	Wheelchair dependent	22
Dependent	30	Ambulatory dependent	22
Dressing - Independent	65	" independent	56
Dependent	35		
Toileting- Independent	70	**Education**	
Dependent	30	College graduate	3
Bathing - Independent	65	Some College	8
Dependent	35	High School graduate	30
		Some High School	32
		Completed Grade School	27
		Some Grade School	0

ILP Population Characteristics

The clients in the Independent Living Program have physical disabilities that are mainly orthopedic and in this respect can be considered a homogeneous group. As noted in Table 1.6 (below) approximately 80 per cent of the group have disabilities that are stabilized and only a few show a pattern of slow physical deterioration.

TABLE 1.6

DISTRIBUTION OF ALL ILP CLIENTS
ACCORDING TO DISABLING CONDITIONS
(N-74 = 100 per cent)

Characteristics	No.	p.c.	Characteristics	No.	p.c.
Disabling condition			Prognosis		
Poliomyelitis	6	8	Improvement possible	6	8
Cerebral Palsy	29	39	Stable maintenance	56	76
Multiple Sclerosis	5	7	Slow deterioration	11	15
Other Neural Disorders	10	14	Fast "	1	1
Arthritis and joint diseases	6	8			
Spinal Defects	11	15			
Amputation	4	5			
Paraplegia (non-polio)	3	4			

The large number of cerebral palsied (CP) in our program appears to be in line with the heavy concentration of this group in the national pattern of disabling conditions; it is estimated that there are almost 600,000 CPs in the United States. The age span for the clients in our program includes mainly those who are in the age range of 18-50 years old. As cerebral palsy is one of the most common disabling conditions found in this age group, it follows that a program of this nature would include many from this particular grouping.

The few clients who have multiple sclerosis have been included to provide a test as to the feasibility of placing persons with this type of disability in a foster home.

Functional abilities. As there could be a wide range of abilities under each diagnosis in so far as performance of activities of daily living is concerned, data on this are given in Table 1.7 (page 25).

Almost 50 per cent of the clients in the program have been disabled from birth (Table 1.8, below). (All but one of these are CPs.) The presence in the Independent Living Program of this large proportion of clients who have had a lifetime disability indicates that there are many in general among the cerebral palsied who have not found suitable living accommodations.

TABLE 1.8

AGE OF ILP CLIENTS AT ONSET OF DISABLING CONDITION
(N-74 = 100 per cent)

Age	Per cent
Birth	44
Under 5 years	5
5 - 10 "	7
11 - 15 "	1
16 - 21 "	8
Over 21 "	35

In view of the substantial number of this sub-group in the project, it may be possible to generalize from many of our conclusions to the broader grouping of CPs. The possibility of institutionalization, for example, is a question which troubles the families of many severely handicapped cerebral palsied children. If a family resolved the question in favor of keeping the handicapped child at home during childhood, the problem may arise again when parents become elderly or too ill to provide the physical care necessary, or when they become concerned about what will happen to the CP after their death. The project indicates that many of the CPs (specifying functional limitations) can make a successful adjustment in the community through foster home placement, then parents might be more likely to keep the CP child at home during the early years.

TABLE 1.7

FUNCTIONAL ABILITIES OF ILP CLIENTS
(N-74 = 100 per cent)

Activity	No.	p.c.	No.	p.c.
	Dependent		Independent	
Personal care				
Eating (incl. special equipment)	20	27	54	73
Bathing	30	41	44	59
Toileting	24	32	50	68
Dressing	24	32	50	68
Household tasks				
Preparing and cooking foods	48	65	26	35
Light housekeeping	48	65	26	35
Shopping, marketing	52	70	22	30
			No.	p.c.
Communication skills				
Speech:				
completely intelligible; can be understood without difficulty by a stranger			48	65
speech is intelligible; however minor impediments are noticeable			11	15
some difficulty in being understood by a stranger; while speech is awkward, he is able to get ideas across			12	16
hard for stranger to understand; difficult for person to get ideas across as speech is barely intelligible			3	4
Hearing:				
no functional hearing loss			67	91
slight functional loss; generally adequate for normal conversational requirements			4	5
moderate functional loss; capable of getting gist of normal conversation			3	4
Reading:				
reads newspaper without assistance			70	95
Telephoning:			69	93
Writing:				
writes legibly			42	57
" fairly well			22	30
cannot write			10	13

The acceptance of a handicapped person into one's home requires a good deal of courage and patience. An analysis of a cross section of the clients in the project shows that there are many whose physical appearance would probably be repulsive to the general population, particularly when there is frequent interaction on an all-day basis in the home. A number of our clients (the CPs) have physical characteristics that have been found to be among the most objectionable to the general public. These groups, which include those with involuntary movements and facial disfigurement of some type, constitute approximately 40 per cent of the clients in the project. Their initial acceptance by "foster" families at least indicates that there does exist families who will accept a disabled person with this physical appearance. Obviously no generalization can be drawn as to the possibilities of acceptance by families other than the "types" that are found in this sample.

In Table 1.9 (below), there are data concerning the SWs description and opinion of the clients' appearance.

TABLE 1.9

DESCRIPTION OF CLIENTS' APPEARANCE
ACCORDING TO SWs
(N-74 = 100 per cent)

Description		Per cent
Dragging, deformed, or awkward:*arm		8
	leg	22
	deviation of one side	20
	no deviation	50
Involuntary movements:	part of body	20
	head	8
	face	18
	none	54
General appearance:	attractive	54
	somewhat awkward	35
	generally awkward	11

*Does not include wheelchair-bound clients who have "good" appearance.

Mobility. The disabled clients in this study compose two distinct groups insofar as their mobile abilities are concerned. One group, almost half of the population, cannot make use of most means of public transportation (unless they are physically carried into taxis) and are generally restricted in their ability to get around, although they are not bedridden. This group, which comprises mainly those who are wheelchair-dependent, had, in effect, decided that even though they would be restricted mainly to the homegrounds of their adopted family, they were anxious to make a change from their previous residence. Although New York City is not the ideal place in which to find homes for wheelchair patients and although these clients pose a major logistical problem for a family, the fact that almost one-third of the population that falls into this category could be placed, strongly supports the belief that it is feasible to find a home for almost any type of person who is not totally bedridden.

Many of the clients can and do make use of a special transportation service for the disabled. However, the limited nature and high cost of this service makes it prohibitive for most clients. A special transportation service for disabled clients in large urban areas would be a major step in assisting these disabled individuals to make greater use of the existing facilities and provide them with an opportunity for more varied activities. Table 1.10 (page 28) shows the proportion of the project clients in the varying degrees of mobility.

Summary of Description of ILP Clients

1. Personal care. Approximately 50 per cent of the clients could not function without the assistance of some other person present. The needs of this group in the area of "personal care" mainly revolve around the need for assistance in bathing, although a considerable number also need minor assistance in dressing.

   The broad range of types that are acceptable, initially at least, to "foster" families, includes handicapped persons who require assistance in an area listed by many as the most objectionable,--in toilet activities.

TABLE 1.10

MOBILITY OF ILP CLIENTS
(N-74 = 100 per cent)

Degree of mobility		No.	Per cent
Wheelchair independent		5	7
Wheelchair dependent		21	28
Ambulatory dependent		15	20
Ambulatory independent		33	45
Independent (needs no assistance):	Climbing stairs	36	48
	Using bus	31	42
	Using subway	28	35
Semi-dependent (needs assistance for at least part of activity):	Climbing stairs	19	26
	Using bus	6	8
	Using subway	6	8
Dependent (needs total active assistance or cannot use facilities):	Climbing stairs	19	26
	Using bus	37	50
	Using subway	42	57

2. Household tasks. An even larger number, 70 per cent, of our population requires that someone shop and prepare food for them and perform the daily household tasks.

3. Communication skills. Although most of the disabled clients are intelligible, there is a small number (approximately 15 per cent) who have difficulty in being understood, because their speech (not their hearing, however), is impaired. This group requires unusual patience on the part of the foster family.

4. Acceptance of the handicapped who required intensive care and patience. Handicapped persons who have many needs, including those involving personal care

in sensitive areas (toilet), and who are severely handicapped (in wheelchairs and with tremors or uncontrolled movements) can be placed with families.

5. Socio-demographic characteristics of client population. The clients are about equally distributed between males and females who are single. They are predominantly white. Most of the clients were born in the United States, many in New York City.

   The religious affiliations of the clients indicate a large number of Catholics (more than 50 per cent of the group) and about 30 per cent Jews. This pattern would fit in with the general distribution of these groups in the New York City population.

A Comparison of ILP Clients with Non-placed Referrals

Some idea as to the type of population that finally became part of the ILP program is provided by a comparison of the ILP clients and the clients who were referred to the program but did not become a part of it. (Table 1.11, pages 30-31)

The ILP population, according to the comparative figures was comprised of a substantial number of the cerebral palsied whose disability was in most cases a lifelong one. Although there was little difference among those who were wheelchair-bound, the ILP clients were in greater need of personal assistance in a number of areas than was the referred population as a whole.

These statistics illustrate that the ILP population was the most severely handicapped of the large group referred to the agency and in this sense constituted an extreme group.

Reasons for Rejection or Withdrawal of Referrals

Approximately 250 disabled potential clients were referred to, or made inquiries about, the ILP. Of these, approximately 30 per cent were placed in foster homes while another 10 per cent received some type of counseling. The other 60 per cent were rejected or withdrew from the program (see Table 1.12, page 32.

TABLE 1.11

COMPARATIVE STATISTICS ON THE CHARACTERISTICS OF ILP CLIENTS AND NON-PLACED REFERRALS

Characteristics		Clients Per Cent (N-74 = 100%)	Non-placed Referrals Per Cent (N-109 = 100%)
Disabling Condition			
Poliomyelitis		8	13
Cerebral Palsy		39	23
Multiple Sclerosis		8	10
Other Neural disorders		14	11
Arth. & joint diseases		8	7
Spinal Defects		15	6
Amputation		5	7
Paraplegia (non-polio)		4	13
Other (or unknown)		0	8
Personal Care Needs Assistance In			
Eating	yes	27	10
	no	73	90
Dressing	yes	32	17
	no	68	83
Toileting	yes	32	10
	no	68	90
Bathing	yes	41	25
	no	59	75
Age			
Under 25 years		25	32
25 - 35	"	27	22
36 - 50	"	30	26
51 - 60	"	15	18
Sex			
Male		54	56
Female		46	44
Age at Onset of Disability			
Birth		43	27
Under 21 years		22	23
After 21	"	35	27
No Answer		0	23

(continued)

TABLE 1.11 (continued)

Characteristics	Clients Per Cent (N-74 = 100%)	Non-placed Referrals Per Cent (N-109 = 100%)
Mobility		
Ambulatory	71	74
Wheelchair-bound	29	26
Cause of Onset		
Congenital	43	28
Illness	47	40
Accident	10	6
No Answer	0	25
Previous Environment		
Hospital	50	58
Unsuitable Environment	50	40
No Answer	0	2
Pre Placement Employment		
Employed at one time	72	68
Never employed	28	32
Marital Status		
Married	5	8
Single	76	75
Widowed	5	1
Divorced	9	9
Separated	5	7
Race		
White	78	81
Negro	14	15
Puerto Rican	8	5
Religion		
Protestant	12	29
Jewish	28	30
Catholic	60	41

TABLE 1.12

DISPOSITION OF REFERRALS TO ILP
(N-250 = 100 per cent)

Disposition	No.	Per cent
Placed in foster homes	74	30
Not placed - received counseling	25	10
Rejected or withdrew	151	60

An analysis of the reasons for the rejection or withdrawal of the clients is given in Table 1.13, page 33. Unfortunately, it was not possible in all cases to obtain information regarding reasons for withdrawal. However, there is information on a sufficient number to provide us with substantial data about the major conditions for these decisions. It would have been beneficial to have interviewed many of the dropouts to gain some insight into the dynamics involved in the potential clients' decision.[12]

It is apparent from the statistics on the number of clients who were rejected by the hospitals for program participation that the hospital staff did not feel that some of the disabled patients were ready for life in the community. This factor has been commented upon previously. Those who are included in this group are those who came to the attention of the agency in some other manner, including self-referral or referral by someone connected with the institution. A substantial number in this group were apparently mentally ill to the degree that they could not participate in the program. Many of these must have been severely mentally ill or else did not receive as favorable a decision as did others who were mentally ill but were still accepted into the program. There is probably a considerable number of potential clients in institutions for the mentally ill who are disabled and who could probably be sustained outside in the community.

The major reasons for clients' withdrawal is apparently the desire to return to their own family setting or to arrange for some other type of independent living. In view of the large number who were apparently seeking assistance in acquiring living accommodations other than a "foster family," some agency should be established which would assist this particular group in making satisfactory arrangements, thus preventing their deterioration and return to an institution.

TABLE 1.13

REASONS FOR REJECTION OR WITHDRAWAL OF REFERRALS*

Reasons	Per cent
Basis for rejection by agency or hospital: (N-29 = 100 per cent)	
Physical - Too severely handicapped	24
- Requires too much medical attention	7
- Hospital staff felt client was not ready for placement	34
Mental - Mentally ill, drug addict	35
Client withdrew because of desire for different type of setting: (N-70 = 100 per cent)	
Desired to remain in the hospital	7
Wanted own apartment or hotel	19
Returned to own family	34
Made own arrangements (Information not available)	
Time - only temporary stay in NYC	5

*The figures in this section do not coincide with the figures given elsewhere because in a number of cases, very little information was available about the client.

V. PRE-PLACEMENT ROLE OF THE CASEFINDER AND ASSIGNED SOCIAL WORKER

The first meeting with the client and the pre-placement period are so important that the various steps of the procedure in the ILP will be given in some detail.

Pre-placement Role of the Casefinder

Clients who were in institutions and were interested in placement in a foster home in the community were first

visited by the agency's casefinder. This procedure was followed so that the casefinder could determine by visiting the patient whether or not he was too physically disabled to participate in the program. In a number of cases, the casefinder decided that the client would be suitable for the program if he received further physical therapy or some other form of rehabilitation that would make him more self-sufficient. The casefinder then contacted the appropriate personnel and made arrangements for the client to receive maximum physical rehabilitation treatment. (In a number of cases the clients had not received the type of rehabilitation that would have made them more independent. Within the confines of the institution, it was possible for them to remain at a more minimal level of physical functioning. However, the needs of living in the community required that some clients receive further rehabilitation. A number of clients who were accepted into the program from unsuitable environments in the community were also, under the guidance of the agency, able to receive further rehabilitation services prior to their moving into a foster home.)

Although the casefinder was also expected to determine whether or not the client was too emotionally disturbed to participate in the program, it became apparent after the first few cases that this "elimination criteria" was not feasible, as many of the institutionalized clients could be categorized as displaying a high degree of personality disorganization and poor emotional control.[13] It was felt that perhaps counseling and participation in the program would in effect constitute a form of "environmental and personal therapy" and be beneficial even to the clients who gave evidence of personality disorganization.

Pre-placement Role of the Social Worker

When the casefinder accepted a client for the project, he was then assigned to a social worker. Information about the client's personality, behavior and attitude was collected from a number of sources. In some cases, reports by clinical psychologists were available, and in most other cases the social workers (including MSWs from the institution) filled out quantitative and qualitative questionnaires, regarding the client's personality.

The social worker (SW) assigned to the client had an opportunity to know the client rather well before the actual placement. From the initial contact to the placement, the SWs and the homefinder were working on the following factors:

1. obtaining from the hospital or another institution the maximum rehabilitation procedures for the client;

2. working out the details involving finances and other services with such agencies as the Department of Welfare and the Division of Vocational Rehabilitation;
3. processing available homes in the agencies file of potential foster homes to determine their suitability for the client, and meeting with potential foster home families to discuss the placement;
4. obtaining the necessary background information about the client's personality, physical health and limitations and financial status;
5. discussing with the client the problems of adjustment he would encounter in the community and working out the details of placement.

Each of the SWs recorded the number, type and means of contact with the client and others who were in some way involved with the client. A detailed analysis of this data was performed, particularly with respect to content for the telephone calls made by the SW, which took up about 25 per cent of her time.

The types of services needed by the client from others that were arranged for by the SW can be summarized in the following categories:

1. Obtaining material goods and services for clients:
   a) Monetary allocations: client's need for additional money or for money not received from Department of Welfare;
   b) Need for equipment: specialized equipment for a disabling condition;
   c) Transportation: arrangements for special transportation for clients.

2. Obtaining information regarding client:
   a) Information about the client - need for records from agencies client had been in contact with;
   b) Technical information about services available - need for information about vocational, educational, medical and recreational services that client might use.

(Note: The appendix contains a more specific list indicating the clients' varied needs and the contacts made by the SWs.)

The Mental Health of ILP Clients

Although initially one of the major criteria for excluding potential clients from the program was the degree of

personality disorganization manifested by the client, in reality this factor was overlooked in many cases. It is possible that if the criterion of personality disorganization were exercised rigorously, there would have been far fewer clients in the program. The analysis of a disabled client's personality is frequently confounded by lack of a definition of the "normal" disabled personality.

Many disabled persons react to situations with patterns of behavior which would generally be classified as indicative of personality disorganization, but the fact that they are disabled somehow seems to make the behavior seem normal. It is also possible that in the emphasis on the physical aspects of the disabled, general behavior characteristics do not seem as important as functional abilities. One researcher found that a number of patients at a rehabilitation institution manifested personality disorders or neurotic reactions such as pathological dependency, schizoid personality reactions and paranoid reactions, but that these disorders were more or less unrecognized.[13] In another major study on the disabled, after careful investigation of the personality disorders of the population, the researchers found "that 48 per cent of the population (almost half), did have psychological problems serious enough to warrant some kind of specific treatment or service if the rehabilitation goals were to be attained."[14]

VI. FAMILY BACKGROUND

Further indications of the client's problems were based on information about the early childhood of the clients. Although we did not have complete information about all of the clients, some had been seen by many agencies and through these sources and interviews with the clients we were able to reconstruct some of the parents' interaction with these clients during their childhood.

In a recent study, researchers[1] have noted the high level of personality impairment that can be expected based on the presence of the following factors in the childhood of the individuals. These factors were found to have been present in

the life history of our clients are presented in Table 1.14 (below). At least 41 per cent of the clients (for which we had background information) came from broken homes or disturbed families.

TABLE 1.14

CHARACTERISTICS* OF PARENTS OF ILP CLIENTS
(N-74 = 100 per cent)

Parent	No.	Per Cent
Psychopathic	5	7
Alcoholic	8	11
Divorced	3	4
Deserted	3	4
Physically Ill	5	7
Died	4	5
Separated	2	3
Total	30	41

*In a number of cases there was more than one condition present in the childhood of the client but the one is listed here that appeared for these summary purposes to be the most detrimental to the personality.

As family life has such an important role in forming personality and attitudes, it is interesting to note the home setting of some of the clients.

	No.	Per Cent
Step-parents	8	11
Foster parents	3	4
Institution	12	16
Total	23	31

VII. THE FOSTER HOME

Foster family care[15] has been used as a substitute for institutional care for many groups, including children, the aged and mental patients who have left the hospital. Unfortunately, the dynamics of the role to be played by the foster home in each of these cases have not been clearly developed. The broad range of factors inherent in the different types of homes, including such features as family composition, type of residence, age of members of the household, combined with the variety of types of clients who were placed in these residences, made it impossible to determine adequately the effects of this type of living arrangement. Statistically, many more cases were necessary, and much less heterogeneity, to be definitive in this area. However, many of the difficulties encountered have been analyzed in each stage of placement and adjustment in order to make judgments regarding the feasibility and advantages of this type of living arrangement.

The Foster Family--A Link to the Community

The acceptance of the handicapped clients by families in the community was an unknown factor. The foster families in this project were not expected to serve in the same capacity as foster parents of children. The foster families were not expected to be the factor in determining the successful adjustment of progress of the handicapped client in the community. It was felt that many of the other forces impinging upon the client (vocational, interpersonal) would also play a major role.

Although the foster family was expected to provide the client with a link to the community, the manner in which this would be done was not specifically spelled out, but was indicated in a rather generalized fashion.

The use of the word "foster family" was somewhat detrimental in that not all of our clients were interested in this type of structure. "Foster family," originally thought of as a substitute for a child's original parents, was a difficult concept to work with and had its negative attributes for a number of clients. Those interviewed in the sample who remained in one institution, and who did not indicate an interest in the program even though they were interested in moving out of the institution, objected to the "foster home" approach. For a number of these clients who had parents still living, an acceptance of a substitute home would indicate acknowledging rejection by their own parents. Although the parents may have had valid reasons for not keeping them at home, individuals who suffer from consistent rejection find it difficult to accept even valid decisions when it involves some apparent slight from their families. The emotional overtones that arise whenever "home" is introduced may demand a concept different from that of foster family.

Locating Foster Homes--A Needle in a Haystack

To obtain information about the physical facilities of housing in New York City, the various research directors of the housing agencies and real estate boards were contacted. It was hoped that detailed information could be found about the size of bathrooms and general access areas in various neighborhoods of New York City and that those areas or blocks that were suitable, particularly for wheelchair clients, could be quickly located.

Unfortunately this type of information was only available in the Building Department records, and not in a form which would have made it feasible to use. It would be a complex and time-consuming task to assemble it. Apparently the Building Department records are the only central source of detailed architectural plans of buildings in the city.

Finding a foster home, particularly for those who use wheelchairs is a time-consuming and expensive task. In addition to having to meet some general criteria in order to be classified as "suitable," the family must also have a suitable physical plant. A wheelchair client needs an apartment or home that has wide entrances to rooms and hallways and access to many facilities, but unfortunately a good part of New York City housing was not built with this criterion in mind.

1. Types of media used to recruit foster homes. At the outset of the project, an attempt was made to reach potential foster families via the mass media, through announcements on major radio networks and through ads in major daily newspapers.

The radio announcements produced a deluge of letters and phone calls from foster family applicants (see Table 1.15, below).

TABLE 1.15

FOSTER FAMILY RECRUITMENT RESULTS FOR ILP

Source	Response*	Accepted	Per Cent Accepted
Radio Announcement	800	100	12.5
Newspapers	700	110	16
Word of Mouth (clients or other foster families)	200	40	20
Social Worker in other agencies	40	15	37.5

*Figures are approximate.

2. Characteristics of foster family applicants responding to a mass media appeal. On the basis of those who completed any of the simple questionnaires or who gave sufficient information over the telephone, it was possible to form a picture of the types of families that were willing to assume the obligations and responsibilities of providing a foster home for an orthopedically disabled person. There was a heavy preponderance of upper-lower-class to lower-middle-class families. This group was mainly composed of women between the ages of 36-55 who were housewives and whose husbands were unskilled or semi-skilled workers with incomes of $7,000 or less. Catholic and Protestant (mainly Negro) groups predominated, and they were found to live in one or two-family homes, in communities composed mainly of such private homes.

   The main reason for many applications was financial. In many cases this was spelled out explicitly; however, it does not necessarily mean that this was the sole reason for applying.

3. Analysis of media and methods used to recruit foster families. At the onset of the project, announcements on the radio and articles in the newspapers were the means by which appeals for foster families were made. Although not all of the responses have been recorded and some of the responses were for requests made at later dates in the program, most of the responses of this type were made during the first year.

   The next stage in the search for suitable foster homes entailed selective approaches via specialized newspapers (foreign language or local), and through local groups (churches and synagogues). This feature was introduced to find homes for specific clients who required a home that would meet certain criteria set up by both the client and the social worker as most suitable for the client. These replies are included in the column "Newspapers" and were not broken down into "specialized" and "general" (metropolitan). At the same time, agencies were informed about the project and became familiar with it through the usual informal channels that exist among social agencies and organizations. Disabled persons, their families and other foster families also brought the program to the attention of potential foster families through word of mouth.

An evaluation of the effectiveness of the recruiting programs and a decision as to which was the most useful would depend on the criteria used to judge them. It appears that although the mass media publicity resulted in many replies and therefore in a tremendous amount of paper work, it did result in the initial acceptance of a large number of foster homes. The fact that not even all of the accepted homes were used indicates that prior to this type of appeal, there should be a large backlog of clients available for placement.

Another important factor which could reduce somewhat the number of unsuitable replies would be the inclusion in the announcement of more detailed information about the types of homes that may be suitable and the type of work the foster parent might be required to do. This conclusion is supported by the information compiled on the

"reasons for rejection and withdrawal of applicants who applied to become foster families" which can be seen in Table 1.16 (page 43). The greatest number of those who were rejected had physical facilities unsuitable for any of the clients, and included such limitations as too many steps, no spare room, bathrooms too small or up stairs, etc. Many others "changed their minds" or their "plans" ans were probably drawn from the group of "impulse" respondents who appear in every similar type of appeal.

One of the key problems was that of finding homes that had a suitable physical environment for wheelchair clients, particularly homes with a bathroom which could accommodate these handicapped persons.

Methods of Choosing Foster Homes

The following is a list of considerations that influence the choice of homes.

1. Physical criteria. A set of criteria was set up by the Department of Welfare and in such cases where the client was receiving public assistance, these criteria were, of course, always met before placement. As the great majority of clients were receiving this assistance, in effect, all of the homes were accepted with the same criteria in mind.

   The homes were categorized also as to the feasibility of placement of a wheelchair-bound client. In some cases, physical changes were made by the agency, such as building a ramp, widening doors, lowering a sink.

2. Personality of family. There was some assessment made of the personality of the foster mother and the general family structure to eliminate those who were most obviously emotionally disturbed but very few foster families were rejected on this basis. Only 3-5 per cent of the homes were rejected for these reasons. The procedure that was followed then was to accept most homes that met the physical criteria and then to find a client who was suitable for the family, or to place a difficult client with any foster family that would accept him.

TABLE 1.16

BASIS FOR REJECTION OR WITHDRAWALS OF SOME APPLICANTS WHO APPLIED TO BECOME FOSTER FAMILIES (SAMPLE OF NUMBER WHO APPLIED) (N = 500)

Reason	Number
Physical facilities of home found to be inadequate for any of the clients	167
Broke off contact--failed to call back or keep appointment	77
"Changed Mind" or "Changed Plans"	67
Moving--new location inadequate	39
Rented to another boarder	28
Death or illness in the family	28
Application not found at given number	24
Considered emotionally ill	19
Member of the family objected	15
Other: had language difficulties; decided "it would be too much work"; located outside of greater metropolitan area; too many persons in the home; type of client requested not available	

3. Analysis of community structure. Although it was apparent that the community facilities were an important factor in the placement of a client, particularly recreational facilities and those that allowed the client to engage in a wide variety of activities (shopping, worship), it was not always possible to place clients in a home that was readily accessible to these facilities. The degree to which the absence of these facilities played a role in the failure of the clients to adjust, or provided them with

a reason for moving, will be determined from some of the analysis on client movements and failures to adjust.

Characteristics of the Disabled Clients Which Made Them Difficult to Place

An analysis of the data (which included information about the type of applicant the foster family would least prefer or be most disturbed by) indicates that a combination of factors, particularly limited physical facilities and a general personality factor, influences placement of difficult clients.

Although the number of foster home applicants expressing a personal dislike for a disabled client with a certain diagnosis was quite small (approximately 10 per cent) it was perhaps indicative of the sentiment of a larger number who would not express an open dislike for a particular disability because of their great interest in obtaining a client. Apart from specific physical disability, the other preferences expressed by the foster family are shown in the following list.

1. Kind of patient whom applicant would not prefer:

   a) wheelchair;
   b) spastic or unable to use hands (for self-care);
   c) difficult speech.

2. Age of preference:

   a) makes no difference--approximately 50 per cent;
   b) 18-25--approximately 25 per cent;
   c) 25-40.

3. Sex preference

   a) female (approximately 50 per cent of the foster mothers);
   b) makes no difference;
   c) male.

4. Educational level preference:

   Approximately 95 per cent indicated it made no difference as to the level of education attained by the client.

5. Religious preference:

   For approximately 80 per cent of the clients, the religion of the client made no difference.

The major group that indicated a choice was the Jewish group.

6. Characteristics most desired in the disabled client by the foster mother:

   The personality or behavioral characteristics most desired by a large number of the foster mothers were: outgoingness, warmth, calmness, neatness, and orderliness (in that order).

7. Applicants indicated they would be most disturbed by clients with the following characteristics:

   Frequent depression, dependence, nervousness, and slovenliness.

8. For those who expressed a willingness to help a disabled client with some of the activities of daily living, the order of preference was as follows:

   a) eating, dressing and walking;
   b) toilet activities;
   c) assisting client with a prosthesis.

The composite picture of the type of client preferred by the foster mothers would be that of a woman, outgoing and warm, who could take care of most of her own needs, be neat and not be frequently depressed. It would appear that many of the foster mothers were looking for a companion who would also provide monetary compensation.

This conclusion is substantiated by interviews with foster mothers in which approximately 60 per cent listed the monetary compensation and the desire for company as the major reasons for accepting a handicapped person into their home. Approximately 65 per cent of the foster mothers are married, with the remaining group generally living alone (widows, separated).

The group of foster mothers willing to accept the disabled is apparently somewhat different from the type of foster parent who is willing to accept the aged, or the post-mental hospital patient.[16]

Experience with Other Boarders and with the Handicapped

It was quite unusual to find such a large group of foster parents willing to accept the disabled into their homes. At least, this was the view held by many who are familiar with the difficulty in finding residence for the handicapped.

An analysis of the group of foster parents indicates that the population is composed of at least 50 per cent of families who have had other roomers or boarders in the house, more than 75 per cent who have had some type of relatively close contact with a disabled person, and approximately 15 per cent who have worked in some professional capacity with the disabled.

Placement of clients in a foster home was done on the basis of only a few selective criteria. These concerned the nature of the client's disability and the need to assign clients to homes where problems with physical facilities were at a minimum. Thus clients who were wheelchair-bound were the most difficult to place. The only other major factor considered was the placement of white clients in Negro homes. Unfortunately the Negro home has the stigma of low socio-economic status (although this was certainly not true in many cases), and was rejected by most of the disabled whites. Their view in this respect did not differ from that held by most of the non-disabled in the community. The disabiled were always fearful of participating in a manner which would downgrade their socio-economic status or label them lower-class.

Although religion was a limiting factor in placement for some, particularly the Jewish clients who requested a home with Jewish foster parents, it was not a major factor when it came to placing other clients.

Social Worker's Attitude Toward Acceptance of Homes

Although the SWs did turn down a number of homes as being unsuitable, only in a small number of cases was the personality of the foster parent a factor in the rejection.

The view of broad acceptance of a variety of personality types was held because of the reality of the situation, viz., the difficulty in finding enough suitable homes for placement of the clients. Perhaps this was also another expression of the view held by many of the workers, namely, that they could with appropriate counseling solve any of the usual interpersonal problems that might arise.

SWs Contacts with the Foster Home

Prior to placement, the SW visited the foster home to meet the family and to look at the facilities avaiable in the home. Other contacts were made by telephone and were mainly to confirm specific appointments about the client's arrival or to check on modification or acquisition of facilities for the client, and to discuss any other special needs of the client.

The SW prepared the foster families for the client through discussion of problem areas. The foster mother also received a manual which gave details of the obligations of the foster family and the role of the NYSOH. (See appendix for manual.)

Types of Foster Families Accepted

The foster families who eventually became a part of the program were generally similar to the larger number of applicants who had applied and had followed through after the first inquiry (see Table 1.17, pages 48-49 and Table 1.18, pages 50-51).

The only apparent differences were in the larger proportion of foster families in the 51-60 year old range in the "initial inquiry" group. Although the percentage of housewives is smaller for the NYSOH foster family group, this only arises because of the addition of the category "service" for the group. The husbands of the NYSOH Foster Family group have a higher occupation level (skilled) than we might expect from their comparative proportion in the total applicant population.

The income levels are generally similar although an accurate comparison cannot be made because two different scales of income were used in gathering information about the population.

Variety of Foster Family Types

Although socio-demographic factors are one way of classifying foster families, they appear to be far from an adequate typology when analyzing the type of family that would be suited to meet the needs of a disabled person.

However, there is not currently available any type of framework that would allow for a more meaningful description of a home or a family that could provide for more appropriate decision-making when the foster family cannot be visited or interviewed extensively. Although the needs of the disabled clients vary a great deal, it might be possible to develop "family types" that could meet the majority of the needs of a specified type of disabled person. For example, we found that although one of the families in which the client was placed was highly disorganized, always involved in litigation, the client who had a need for activity and a sense of importance became the organizer and was involved in the detailed activities. This provided him with a zest for living and was an ideal setting for him.

TABLE 1.17

CHARACTERISTICS OF FOSTER FAMILIES*

Characteristic	Wife No.	Wife Per Cent	Husband No.	Husband Per Cent
Age: Wife (N-68 = 100 per cent) Husband (N-47 = 100 per cent)				
Under 25 years	2	3	1	3
26 - 29 "	1	2	2	4
30 - 35 "	5	7	2	4
36 - 40 "	5	7	3	6
41 - 50 "	23	34	14	29
51 - 60 "	20	30	14	30
61 - 65 "	7	10	6	13
65 - + "	5	7	5	11
Occupation: Wife (N-55 = 100 p.c.) Husband (N-43 = 100 p.c.)				
Professional	0	0	2	5
Managerial	2	4	4	9
Small business	3	5	4	9
Skilled labor	3	5	16	37
Salesman	1	2	3	7
Clerical	7	13	1	2
Unskilled	2	4	7	16
Services	13	24	5	12
Other housewife	24	43	1	2
Marital Status: (N-73 = 100 p.c.)				
Married	46	63		
Single	2	3		
Widow	19	26		
Divorced	4	5		
Separated	2	3		

(continued)

TABLE 1.17 (continued)

Characteristic	Wife No.	Wife Per Cent	Husband No.	Husband Per Cent
Income: Husband + Wife (N-89 = 100 p.c.)				
None			25	28
Below $4,000			30	34
$4,000 - $6,000			15	17
$6,000 - $8,000			12	14
$8,000 - $10,000			7	8
Over $10,000			0	0
Religion: Husband and wife singly; (N-122 = 100 p.c.)				
Protestant	44	36		
Jewish	19	16		
Catholic	57	47		
Other	2	2		

*Complete information was not available for the entire group.

For "others in household," there were 124 persons of which 59 or 48 per cent were females and 65 or 52 per cent were males.

TABLE 1.18

CHARACTERISTICS OF TOTAL FOSTER HOME APPLICANT POPULATION*

Characteristics	Wife No.	Wife Per Cent	Husband No.	Husband Per Cent
Age: Wife (N-424 = 100 p.c.) Husband (N-240 = 100 p.c.)				
Under 25 years	2	1	0	0
26 - 29 "	8	2	3	1
30 - 35 "	41	10	15	6
36 - 40 "	46	11	25	10
41 - 50 "	141	32	78	33
51 - 55 "	67	16	49	20
56 - 60 "	43	10	30	13
61 - 70 "	76	18	40	17
Occupation: Wife (N-332 = 100 p.c.) Husband (N-248 = 100 p.c.)				
Professional	3	1	9	4
Managerial	5	1	24	10
Small business	4	1	8	3
Skilled labor	11	3	60	24
Salesman	2	1	5	2
Clerical	22	6	7	3
Unskilled	80	24	104	42
Other, housewife	201	61	0	0
Retired and other	4	1	31	13
Marital Status: (N-452 = 100 p.c.)				
Married	282	62		
Single	13	3		
Widow	104	23		
Divorced	20	4		
Separated	33	7		
Income: Husband + Wife (N-332 = 100 p.c.)				
0 - $3,000			80	24
$3,000 - $5,000			83	25
$5,000 - $7,000			101	30
$7,000 - $10,000			58	18
Over $10,000			10	3

(continued)

TABLE 1.18 (continued)

Characteristics	Wife No.	Wife Per Cent	Husband No.	Husband Per Cent
Religion: Husband and wife singly: (N-354 = 100 p.c.)				
Protestant	106	30		
Jewish	39	11		
Catholic	135	38		
Other	74	21		
Others in Household:	Females		Males	
Female (N-191 = 100 p.c.) Male (N-190 = 100 p.c.)	No.	Per Cent	No.	Per Cent
One other	126	66	127	67
Two others	44	23	48	25
Three others	19	10	10	5
Four others	2	1	6	3

Age of Others in Household: (N-381 = 100 p.c.)	No.	Per Cent
Under 5 years	69	18
5 - 10 "	86	22
11 - 19 "	106	28
20 - 30 "	38	10
31 - 40 "	15	4
41 - + "	67	18

*Complete information was not available for the entire group.

REFERENCES

[1]The terms that are used in this project follow the suggestion of Wright, who quotes Hamilton's definition of "disability" as ". . . a condition of impairment, physical or mental, having an objective aspect that can usually be described by a physician. . . . A handicap is the cumulative result of the obstacles which disability interposes between the individual and his maximum functional level." See Beatrice A. Wright, Physical Disability--A Psychological Approach (New York: Harper and Brothers, 1960), p. 9.

[2]In Long Stay--Hospital Care, the authors found that, "Physical disability and no home or lack of anyone at home to help--homelessness and helplessness--were the chief characteristics of patients who might have been discharged to their homes or to a substitute for home. Such patients totaled nearly half of the 248 patients not medically in need of general hospital care." See The School of Public Health and Administrative Medicine of Columbia University. Study Method and Summary of: Long Stay Hospital Care--Reasons for prolonged stay of 611 service ward patients of all ages, hospitalized thirty days or longer in nine hospitals, municipal and voluntary in New York City, on a Census Day in 1961. Submitted to The Department of Hospitals of the City of New York, 1963, p. 7.

Also note the following studies: Melvin Herman, "Reintegration of Handicapped Persons in the Community" (Paper presented at the National Conference of Social Work, Minneapolis, Minnesota, May 15, 1961), pp. 1-2. Georgia F. McCoy and Howard A. Rusk, An Evaluation of Rehabilitation (New York City: Institute of Physical Medicine and Rehabilitation, 1953). Commission on Chronic Illness. Care of the Long-Term Patient--Chronic Illness in the United States, Volume II. Published for the Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956, pp. 15-16. Julius A. Roth and Elizabeth M. Eddy, Rehabilitation for the Unwanted--A Study of Patients and Their Setting in a Rehabilitation Unit in a Public Chronic Disease Hospital and Custodial Home, Research Center, The New York School of Social Work--Columbia University, 1963, p. 413. The New York Foundation, Hospital Patient Survey--An Evaluation of the Basic Characteristics, Medical Findings, and Potential Disposition of the Patients in the New York Municipal Hospital System with Special Reference to the Problems of Chronic Disease and Custodial Care (New York City, 1956), pp. 123-132. Organized Home Medical Care in New York City--A Study of Nineteen Programs by the Hospital Council of Greater New York. Published for The Commonwealth Fund by Harvard University Press, Cambridge, Massachusetts, 1956, p. 9. For a recent study, see:

Residential Care for Physically Incapacitated Young Adults (Toronto, Ontario: Social Planning Council of Metropolitan Toronto, November, 1965).

Although a number of these studies included large numbers of the elderly (many sixty-five and over), there was sufficient numbers to indicate the need for a special type of living arrangement for the young or middle-aged adult with a physical disability.

A more individualistic note on the need for independent living appears in: Joan Herman, "Why New Horizons," Cheshire Smile (Le Court, Liss Hants, England, Summer, 1966), p. 20: "Some of us live in general hospitals, though we are not sick; some of us live in rehabilitation centres, though these centres can no longer aid our progress; still others of us live in convalescent homes with the passive and elderly, though we aspire to be active and young. We are those handicapped people who are not able to be rehabilitated to home or competitive jobs, because of the severity of our physical disabilities. So we must remain in hospitals and rehabilitation centres, though we no longer require the specific services these institutions offer.

"Our limitations are not only the limitations of a paralyzed arm, sightless eyes, poor coordination, or lack of leg mobility. Most of us require a minimum amount of nursing care and therapy. But we live in institutions geared for those requiring a maximum amount of both and where nursing care and therapy come first. Because of this, the time of the nurse or aide or therapist cannot be employed to augment our creative ability, our longing for fun and companionship and, most important, our need to give of ourselves and our friendship to staff members, thus making the relationship a real one, and a mutual blessing. . . .

"A new departure must be made. A new environment must be found to suit our needs--our need to be useful and creative, our need to pursue happiness within a community of interdependent people. . . ."

[3]Overbrook Hall, a custodial residental center established for the cerebral palsied was closed after a few years because of under-utilization. The committee recommended that "the funds currently being spent on Overbrook Hall would be more wisely used to the benefit of all CPs requiring custodial care, by concentrating UCPA's efforts on locating and making available adequate foster homes, nursing homes and other facilities more suitable for the provision of custodial care." Cited in Final Report of the Senate Factfinding Committee on Labor and Welfare on: The Need for Residential Care of Severely Handicapped Children and Adults of Normal Mentality.

Published by the Senate of the State of California, 1965, p. 56.

[4]Long Stay--Hospital Care discusses some of the key problems in moving custodial patients out of an institution. Long Stay--Hospital Care (The School of Public Health and Administrative Medicine of Columbia University, 1963), p. 9.

[5]See: Julius A. Roth and Elizabeth M. Eddy, Rehabilitation for the Unwanted--A Study of Patients and Their Setting in a Rehabilitation Unit in a Public Chronic Disease Hospital and Custodial Home; A final Report to the VRA for Research Grant Number RD-577 (New York: Research Center, Columbia University School of Social Work, 1963), p. 305.

[6]See: For an expanded discussion on some of the problems mentioned here, refer to the chapter on the Medical Social Worker, in Stanley H. King, Perceptions of Illness and Medical Practice (New York: Russell Sage Foundation, 1962), pp. 279-301.

Also see: Margaret M. Heyman, "A Study of Effective Utilization of Social Workers in a Hospital Setting," Social Work--Journal of the National Association of Social Workers, Vol. 6, No. 2 (April 1961), p. 36.

[7]R.B. Edgerton and G. Sabagh, "From Mortification to Aggrandizement: Changing Self-conception in the Careers of the Mentally Retarded," Psychiatry, Vol. 25 (1962), pp. 263-272.

[8]See: Erving Goffman, On the Characteristics of Total Institutions (Washington, D.C.: National Institute of Mental Health, Department of Health, Education and Welfare, April, 1957).

[9]See: Julius A. Roth and Elizabeth M. Eddy, op. cit., p. 141.

[10]See: Esther Fibush, "The White Worker and the Negro Client," Social Casework, Vol. 46, No. 5 (May 1965), pp. 271-277.

[11]See: H.J. Kallen, "Critical Experiences and Rehabilitation of the Physically Handicapped," Paper read at the meeting of District 2, Maryland State Nurses' Association, Hagerstown, Maryland, April 27, 1961.

[12]See: Herbert S. Rabinowitz, Derwood E. Johnson and

Anthony J. Reilly, "A Preliminary Study of Program Dropouts from Vocational Services," Rehabilitation Counseling Bulletin, Vol. 8, No. 1 (September 1964), pp. 2-7, for comments on this factor.

[13]See: L.A. Gelb, "Personality Disorganization Camouflaged by Physical Handicaps," Mental Hygiene, Vol. 45 (April 1961), pp. 207-215.

[14]Louis E. Masterman, Psychological Aspects of Rehabilitation: Follow-up Study (Kansas City, Missouri: Kansas City Rehabilitation Experiment, Community Studies, Inc., May 1961).

[15]For a discussion of some of the problems related to this type of care see: Martin Wolins, Selecting Foster Parents: The Ideal and the Reality (New York and London: Columbia University Press, 1963); and, "Foster Family Care for the Aged," U.S. Department of Health, Education, and Welfare, Welfare Administration, Bureau of Family Services, Washington, D.C., 1965; and William T. Bowen, M.S.W. and Gloria J. Fischer, Ph.D., "Community Attitudes Toward Family Care," Mental Hygiene, Vol. 46, No. 3 (July 1962),

[16]Also "Foster Family Care for the Aged," op. cit., p. 12. The author notes that: "By far the greatest percentage of foster homes are offered by widows. The widow who assumes the responsibility of caring for an older person does so for various reasons. The motives are financial as well as the desire to be needed, to be responsible for someone else's comfort and welfare. Frequently there is also the question of companionship, of having someone else in the empty apartment or house." Similar results were also found by Bowen and Fischer, op. cit., pp. 404-406, who stated (regarding the acceptability of mental patients in foster homes), that: "The single or divorced are twice as likely to consider taking a roomer or boarder into their home than are the married or widowed. Thirty-eight per cent of the single or divorced replied affirmatively to this question, whereas only 18 per cent of the married or widowed did so. No significant difference between these groups was noted in response to the questions relating to taking a mental patient into the home as a roomer or boarder. It may be that the single or divorced are reflecting a need for companionship, but, at the same time, are avoiding responsibility." They also found that: "The greatest expression of uncertainty about considering accepting a patient was by those under age thirty-five. The greatest evidence of positive interest was expressed by those age thirty-five to age fifty-four, and the greatest evidence of refusal to consider was by those age fifty-five and over."

CHAPTER II

IN-PLACEMENT RESULTS

This chapter contains a report of the number of clients who were successful and unsuccessful (the criteria used for this classification are outlined in this section) and the location and environmental changes of the clients at various intervals. In addition, there is a report on the adjustment and progress the clients have made in the vocational and interpersonal areas including advances in their "quality of living." An analysis of the possible causes for failure or lack of progress, or at least some of the factors related to this condition, will be discussed in the "research and analytical" section.

It was possible to obtain some information on groups whose environmental setting was either different from the project population or who did not receive the same type of treatment. There has already been a comment on the group that had remained behind in an institution and on the reasons for considering the placement in the community superior to institutionalized living for most disabled persons. Although specific information about large numbers of disabled individuals who were referred to the agency but did not become part of the program could not be obtained, there were replies from some of the group on their progress, providing comparative data. On the basis of non-answered returns, noting that the person had

moved, it was possible to make reasonable deductions regarding the number who made environmental changes.

I. TIME NEEDED FOR PLACEMENT

It took an average of five months to place clients in a foster home. This was the time period that elapsed from the time of contact with the client to the time of actual placement, usually following the trial visit. This long period of time was frequently necessary because of the delays in preparing the patient for placement and in finding an appropriate home. Although there is not enough information to determine if many clients dropped out, lost interest or found other less suitable arrangements because they had to wait too long, it can be concluded (see earlier comments on reasons for dropouts) that this may have been the case of quite a few of the clients.

II. CRITERIA FOR SUCCESS

During the course of the study, criteria for success took two levels: first, whether the client was able to remain in the community without severe physical or mental deterioration, and second, if the client was able to make progress in his occupational and social functioning.

Although the two levels were expected to be related, the report on the progress in this section deals with them separately, then shows the interaction between the two in the sense that the presence of high level functioning was a determinant for many, although not all, of the successes and failures.

Classification of Failures

Clients were categorized as "unsuccessful" or "failures" if they fell into any of the following categories:

1. Moved to an environment classified as "unsuitable" (negative). (MU)

2. Entered a psychiatric ward--commitment after a psychotic episode. (PW)

3. Returned to hospital or similar institution (nursing home) on a permanent basis. (I)

4. Showed evidence of severe personality disorganization although client was not institutionalized at that time; prediction was that under other circumstances client would have been institutionalized. (PD)

   The categories are not mutually exclusive. Clients were identified as belonging to one of the categories depending upon their destination if they made an environmental change, or, in the last case, upon reports of their behavior.

Rationale for Choice of Criteria

It was extremely difficult to identify the features which would provide some means by which to evaluate the results of the program. In a sense the evaluation procedure that was adopted focuses on a partial evaluation regarding the value of this type of social work intervention and the use of foster homes, through comparison with those not receiving these services. Some of this information has already been reported and the rest will be discussed in the research chapter. The procedure of establishing success and failure groups allows for a further investigation of the factors that were central in the process of assisting the client in his adjustment or in making progress.

The objective was to keep the client in the community at a level commensurate with intake, that is, without physical or mental deterioration. The various criteria spell this out quite specifically. The "move to an unsuitable environment" was considered as a program "failure" inasmuch as it was clinically decided that certain environments would lead to deterioration, hence the original rationale for moving the clients from these environments. Although it cannot be shown that this is necessarily the case, it was felt that the client's behavior in making this type of move was a "negative" one. A very few clients showed evidence of severe personality disorganization

but managed to remain in a foster home after the episode. These clients have been classified in the failure category for it was the view that except for the unusual circumstances that were present (a degree of intensive casework that was not feasible in and could not be expected from any other program and in a sense was not representative of what most of the other clients were receiving) these clients would have been institutionalized. Their classification as failures allowed an investigation of the factors that might have been related to the breakdown.

It will also be shown in the research section that there was a very high correlation between severe personality disorganization and movement to an institution or unsuitable environment in most of the cases.

Post-Placement Results: Successful and Unsuccessful Clients

The clients in the ILP were in placement for various periods ranging from six months to five years. The breakdown of the results will illustrate the overall picture and the successes and failures according to cohort grouping. (A cohort is defined as a group of clients entering the project during a specific period, in this case a July 1 to June 30 year.)

TABLE 2.1

CLASSIFICATION OF CLIENTS AS SUCCESSFUL OR UNSUCCESSFUL
(N-74 = 100 per cent)

Classification	No.	Per Cent
Successful clients	43	56
Unsuccessful clients	31	44
Sub-total unsuccessful:		
Moved - unsuitable	8	11
Moved - psychiatric ward	9	13
Institutionalized	6	9
Personality disorganization	8	11

Using the stated definition of failure, the results (see Table 2.1, above) indicate that 44 per cent of the clients

were unsuccessful in the community. Although the figure might admittedly be higher if clients were in placement for a longer period of time, an analysis of the time interval of failure shows that most of the clients who fail do so within the first six months and the vast majority before the end of the first year of placement (Table 2.2, Table 2.3, Figure 2.1, pages 61 and 62).

TABLE 2.2

NUMBER OF CLIENTS WHO WERE UNSUCCESSFUL
ACCORDING TO TIME IN PLACEMENT
(N = 31)

Placement Time Interval	Cumulative Number
6 months	16
12 "	23
18 "	28
24 "	29
30 "	30
36 "	31

The total of 31 might appear to be somewhat high until it is seen in the perspective of the type of client who was placed. As discussed earlier and illustrated with comparison groups, the disabled group that participated in this program was a population of severely disabled and emotionally disturbed clients. Had predictive tables been set up at the outset regarding the possible adjustment of the clients, it is doubtful if it would have been predicted that 10 per cent would have continued in the community without deterioration. Furthermore this program was of an experimental nature and much has been learned that probably could have made the difference in contributing to making more clients successful. Finally, as will be shown in the research section, some of the factors that were believed to have contributed to the clients' lack of success were beyond the control of the social workers or of the foster families in the program.

TABLE 2.3

PER CENT DISTRIBUTION OF UNSUCCESSFUL ILP CLIENTS ACCORDING TO COHORTS OF PLACEMENT YEAR AND LENGTH OF TIME IN PLACEMENT

Length of time in Placement	Year of Placement*			
	Group I	Group II	Group III	Group IV
	July '61 -June '62	July '62 -June '63	July '63 -June '64	July '64 -June '
	(N = 35)	(N = 9)	(N = 20)	(N = 10)
	Per Cent	Per Cent	Per Cent	Per Cent
0 - 6 months	23	0	30	20
7 - 12 "	6	22	15	0
13 - 18 "	6	11	10	0
19 - 24 "	3	0	0	0
25 - 30 "	3	0	0	0
31 - 36 "	3	0	0	0
Total Per Cent	44	33	55	20

*As of June 1965, Group I was in placement 3-4 years; Group II, 2-3 years; Group III, 1-2 years; Group IV, 0-1 year.

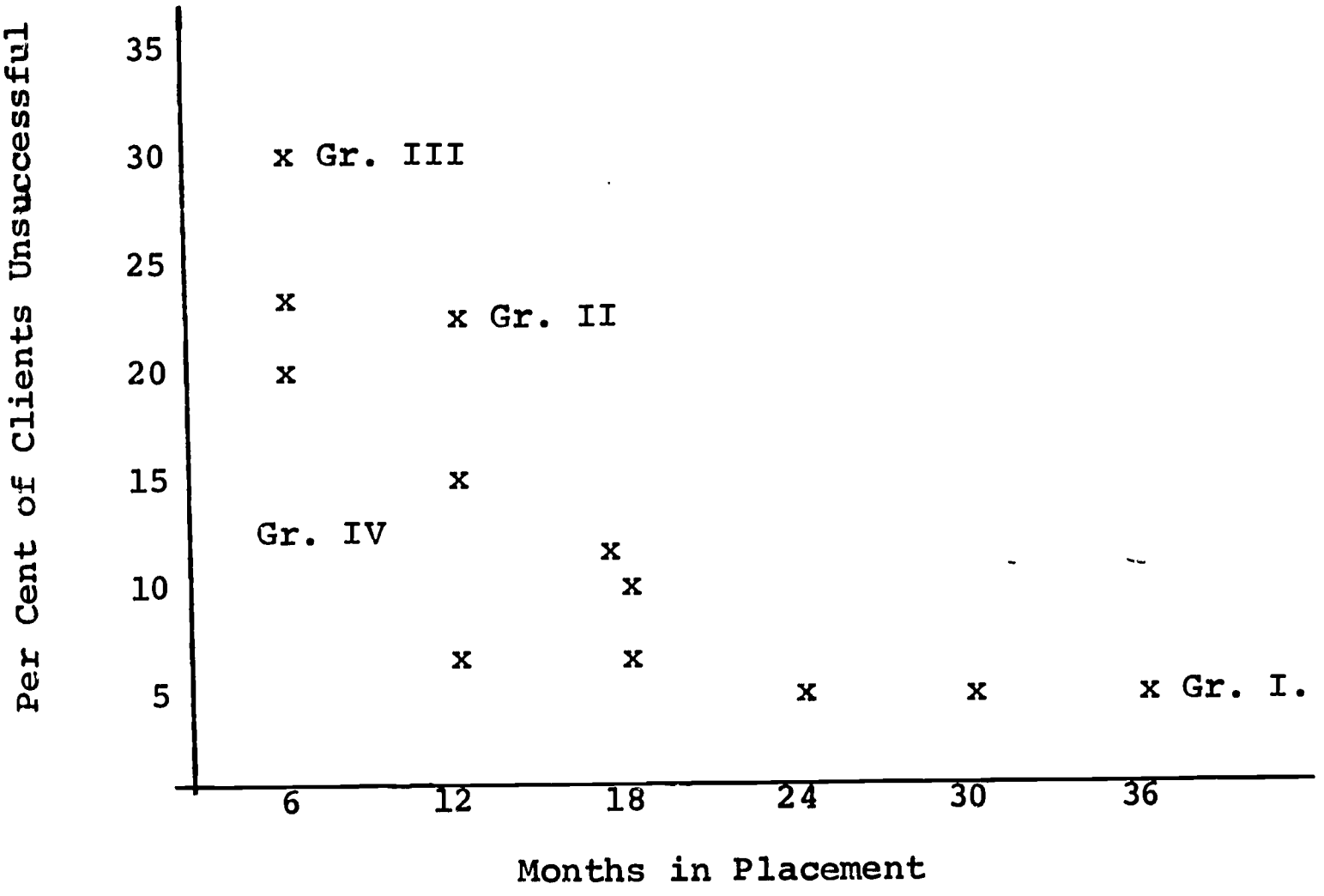


FIGURE 2.1

PER CENT DISTRIBUTION OF UNSUCCESSFUL ILP CLIENTS ACCORDING TO COHORTS OF PLACEMENT YEAR AND LENGTH OF TIME IN PLACEMENT*

*See footnote Table 2.3 for explanation of groups.

Trial Visits

The short trial visits were designed to minimize improper matching of client and foster family. The client visited the potential home usually for a weekend, or, in some cases,

for as long as a week (or, in a very few instances, for only an afternoon). The understanding was that either party could terminate the arrangement if he so desired, and it was this factor, according to the SWs, that encouraged many of the clients and families to make the attempt at placement.

1. Trial visits and severity of disability. Approximately 28 per cent of the clients required more than one trial visit before they were placed. An analysis of these cases indicates that severity of disability was not a major factor in determining the need for an additional trial visit with another family. There did not appear to be a factor common to either the clients or the foster families that could account for the need for additional trial visits.

III. VOCATIONAL PROGRESS

One of the major objectives in moving the client from the institution or from unsuitable environments was to provide him with the type of suitable placement and counseling that would enable him to find some type of employment. There is a school of thought that believes that disabled clients, particularly those who are severely handicapped, should not be expected to work, and that for this group, the value system which places a heavy emphasis on the fulfillment of this role is one that should be changed.

Unfortunately, this society still operates with a set of norms and expectations that even the disabled incorporate into their expectations or in their need to fill the same roles as the rest of the population. Being a worker is still viewed as a role that especially the males in our society are expected to occupy. Although society may not expect the handicapped to meet these role expectations, an alternate role has not been

established, at least not one that does not have the tinge of "charity-welfare" attached to it. The disabled person who is not doing work of some type finds that there is no other role he can assume, and thus loses a sense of self-respect and develops a low self-esteem.

Apart from the value of work in meeting society's role expectations the economic factor, that is, the disabled individual's greater control over his life when employed, is sometimes a forgotten element. Money is still the instrument that can purchase comfort and self-respect, perhaps more so for the disabled than for others. And finally, perhaps work is, as Freud has noted, the bridge to reality. At least it dissolves the lonely hours that many people have to spend and provides for an investment of energy in something that can break up the monotony. For a disabled person, and for many non-disabled, boredom is the greatest of enemies that have to be conquered, and the sharing and companionship that are found on almost all jobs--the human contacts in themselves--form a desired activity.

Employment History

About one-third of the clients were working during the first six months of placement, with the number increasing at a later time as a percentage of the total in placement at a given time as can be seen in Table 2.4, page 65, and Table 2.5, page 66. The largest numbers accounting for the increase are clients who worked full time, many of them moving into this category after working part-time. Although the figures are respectable considering the severity of disability of the population, as will be shown later, the inability of many of the others to find work was one of the unfortunate aspects of the program over which the SWs did not have control. The group

that constitutes the largest number of non-workers are those who have probably never worked to any considerable extent and who were unemployable as much because of their lack of experience as because of their disability. However, disability itself was not the limiting factor for many in the population and a large number of CPs were employed in workshops. The longer a client was able to remain in the community in a favorable setting, the more likely he was to have an opportunity of working.

Many years of discussion of the whole area of work and the disabled have not apparently resolved a large number of the obstacles confronting the disabled. This problem will be analyzed in the research section.

TABLE 2.4

EMPLOYMENT HISTORY OF ILP CLIENTS IN PLACEMENT ACCORDING TO SEX AND SUCCESS OF PLACEMENT
(Male N = 40; Female N = 34)

Employment	Successful M	Successful F	Unsuccessful M	Unsuccessful F
Worked regularly	6	4	1	2
Worked more than half of the time and gainfully employed when evaluated (or move to more independent living)	4	0	0	0
Worked some of the time and gainfully employed when evaluated (or move to more independent living)	2	2	0	1
Worked more than half of the time but not gainfully employed at time of evaluation (or move to more independent living)	1	0	0	0
Worked some of the time but not gainfully employed at time of evaluation (or move to more independent living)	3	4	3	1
Not gainfully employed	5	12	15	8
Total	21	22	19	12

TABLE 2.5

COMPARISON OF EMPLOYMENT STATUS OF CLIENTS AT SOME TIME PRIOR TO PLACEMENT WITH EMPLOYMENT STATUS DURING PLACEMENT

Amount of Time Employed During Placement	Prior to Placement: Full Time	Part Time	Few Hours	None	Total: No.	Per Cent
0 to 6 months: N=74;						
No. working = 25 (34%)						
Full time	3	1	1	1	6	7
Part time	7	3	2	2	14	20
Few hours	1	1	1	2	5	7
None	30	2	1	16	49	66
Total	41	7	5	21	74	100
Left placement before 6 months	11	0	0	5	16	22
6 mos.-1 yr: N=58;						
No. working = 23 (39%)						
Full time	5	3	1	2	11	19
Part Time	4	2	0	0	6	10
Few hours	2	0	2	2	6	10
None	19	2	2	12	35	61
Total	30	7	5	16	58	100
Left placement 6 months - 1 year	5	1	1	0	7	9
No. in placement less than 1 year at termination of project	7	1	1	0	9	12
1 - 2 years: N=42						
No. working = 25 (60%)						
Full time	5	3	1	4	13	31
Part time	3	1	0	2	6	14
Few hours	3	0	1	1	5	12
None	7	1	1	9	18	43
Total	18	5	3	16	42	100

IV. INTERPERSONAL RELATIONS

One of the major problems confronting persons with limited mobility, who comprised a large majority of the clients, was the absence of the opportunity to establish relationships with others. This problem, which also confronts those whose mobility is limited financially or because of age, is central frequently to the mental deterioration of the individual. The vast programs designed to meet the needs of these populations and overcome the loneliness that afflicts so many are indicative of the importance that has always been placed on adequate human contact as a necessity for mental health or for giving meaning to life.

Interpersonal Gains Made by Clients

The data that have been gathered about the interpersonal advances made by the clients was assembled from reports by the social workers as well as directly from the clients. This two-pronged approach was used because of the need of most individuals to deny their loneliness. It was not possible in all cases to obtain the information on all of the clients for many varied reasons. The clients who are included however are, as far as we could determine, representative of the group in many other ways and thus we will generalize our information to the entire population.

A variety of questions in this area were used and we assembled data on the following factors: marriage, friendship, dating, contact with relatives, and broader human contacts as exemplified by the clients taking vacations (particularly at a camp for disabled adults).

1. Marriage. By the end of the first year in placement 6 or 9 per cent of the clients were married. This group included a client who had been institutionalized for twenty-five years and others who were well educated and working full time. In a number of cases, there was intensive counseling by the SWs and the assistance they provided

ranged from birth control and sex education to assistance in obtaining living quarters.

2. Friends. A study of subjective reports indicated that for 32 of our clients, there was little or no change in friendship patterns in the first six months of placement. At the one-year mark, 19 of these clients maintained this status, 2 had increased their frequency of contact with friends, none had decreased in this respect, and 11 had dropped out of the program.

   Of the 24 whose friendly contacts increased by the six-month point, 16 were still "up" after a year, 2 had moved "down," and 6 had dropped from the ILP. Of the 18 whose friendly contacts had decreased in the first six months, 7 remained "down" after a year, 3 increased and 8 dropped from the ILP.

   Thus, of the 49 remaining in the program for as long as one year, only 9 described themselves as having fewer friends than in the pre-placement period. Such a finding was somewhat unexpected, in view of the fact that for some clients placement meant moving away from urban homes and institutions where the opportunity for human contacts was considerable (in terms of old friends, clubs, recreation centers, organized activities, greater population densities, and better transportation) and into suburban homes where these advantages were often lacking.

3. Dating. During the first six months of placement, 17 clients showed an increase over pre-placement dating frequency. At the one-year point, 9 of these remained "up," 5 moved "down" in frequency, and 3 had left the program. Of the 22 clients whose dating frequency was lower at six months, 13 remained lower at one year, 1 moved "up," and 8 left the program. Of the remaining 35 clients, whose dating frequency at six months was the same as their pre-placement figure, 17 were dating more frequently by the one-year point, 2 moved "up," none moved "down," and 16 left the program. No special trends were noted.

   Obviously, dating is generally of greater concern to younger clients. Many of the clients whose dating frequency was low and remained so were from older age groups. Others were limited by their lack of mobility, being confined to wheel chairs,

lack of transportation facilities, or inability to meet the high cost of available transportation. Living in suburban foster homes, especially in areas lacking adequate community centers for the general public as well as for the handicapped, has proved to be an obstacle to dating and other social activities for some clients. In some cases, the only solution was a move to a more centrally located foster home.

4. Contacts with relatives. For those clients whose pre-placement daily life had been spent in the family home or with other relatives, placement in a foster home almost assured a decrease in frequency of contact with these relatives. This was even more so among clients whose placements had been necessitated by unhappy home situations, or by situations where the physical condition or mobility of the client or family precluded travel between foster home and former place of residence.

   Thus, it is not surprising to learn that (see Table 2.6 below and Table 2.7, page 70), of 14 clients who saw their relatives more than once a month before placement, 7 maintained this frequency and 7 decreased it during the first year in placement. Of 2 who saw their relatives every few months or once a year, both had no visits during their first year in placement. However, 5 who reported that they never saw relatives during the pre-placement period, 2 now saw them once a month or more, 1 every few months, and 2 still never saw their relatives. Data are lacking on the remainder of the sample.

TABLE 2.6

COMPARISON OF ILP CLIENTS' CONTACTS WITH RELATIVES, BEFORE AND DURING PLACEMENT (N = 21)*

	6 Months - 1 Year in Placement			
Pre-Placement	Once/mo.	Every few mos.	Once/yr.	Never
Once/month	7	3	2	2
Every few months	0	0	0	1
Once/year	0	0	0	1
Never	2	1	0	2

*Pre-placement data were not available on the entire sample.

TABLE 2.7

ILP CONTACTS WITH RELATIVES, ACCORDING TO PRE-PLACEMENT LOCATION AND TIME IN PLACEMENT

Pre-placement location	Once/ Month	Every few Months	Once/ Year	Never
First 6 mos. in placement: (N = 53)				
Institution	16	4	0	7
Nursing Home	0	0	0	1
Unsatisfactory environment	11	1	1	0
Hotel or rooming house	2	4	1	2
Social agency residence	1	0	0	2
6 mos. to 1 yr. in placement: (N = 44)				
Institution	10	4	2	5
Nursing Home	0	0	0	0
Unsatisfactory environment	8	1	0	5
Hotel or rooming house	2	0	0	4
Social agency residence	2	0	0	1
1 to 2 yrs. in placement: (N = 40)				
Institution	13	3	0	2
Nursing Home	1	0	0	0
Unsatisfactory environment	7	0	0	3
Hotel or rooming house	3	1	0	4
Social agency residence	1	0	0	2

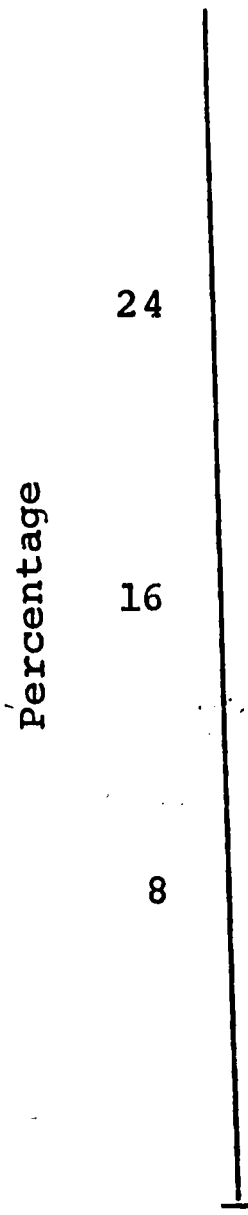
5. Vacations and camp. Of the 74 clients, 35 showed a rise in camp attendance and vacation activities during their first six months in placement. After a year, 21 of these maintained this rise, 3 showed a decrease, and 11 had dropped from the program. Of the 28 who at six months showed no change from their pre-placement activities, 11 maintained this status at one year, 4 increased and 2 dropped out. Of the 11 clients whose vacation activities were down at six months, 8 remained low after a year, 1 increased, and 2 dropped out.

Thus, after one year, 40 clients showed a rise in vacation activities at some time during placement. This longer time period allows for seasonal variations in vacation opportunities. Compared with such other interpersonal activities as friendships and dating, there was a more obvious increase in vacations and camp attendance. This was probably due in part to the fact that the sponsoring agency operates a summer camp for handicapped adults.

Moreover, it is apparent that some institutions for the chronically disabled whose bed space is at a premium, are administratively inconvenienced by short vacations for inmates, and thus do not encourage this. In contrast, the foster homes often welcomed vacations for the clients, since this gave the foster family opportunities for their own vacations by temporarily relieving them of their responsibilities. Finally, it should be noted that for some clients, the vacation or camp experience was their very first, and represented a step forward in independence and self-reliance.

VI. CLIENTS' DESTINATION

Of the 25 per cent of the clients who left the foster home in the first six months, about one-third of these moved to another foster home, while the remainder took many different courses (see Table 2.8, page 73). The next largest group returned to their own family, and a somewhat smaller number returned to an institution. Considering the extreme nature of the overall client population with respect to background history, physical disability, and personal-emotional problems, and in view of the relatively random nature of the placement process (after proper qualification of client and foster home), it is indeed surprising that as many as 75 per cent of the group are able to remain in a foster home placement for the critical first six months (see Figure 2.2, page 72).



	0-3 mos.	3-6 mos.	6-9 mos.	9-12 mos.	1-2 years	2-3 years	over 3 yrs.
Group N	16	11	3	2	8	4	3
Total N	74	74	74	74	61	41	25

FIGURE 2.2

TIME WHEN CLIENTS MADE FIRST MOVE
FROM A FOSTER HOME BY PER CENT
OF GROUP IN PLACEMENT

TABLE 2.8

LOCATION OF CLIENTS ACCORDING TO TIME IN PLACEMENT

Time in Placement	Foster Home No.	Foster Home p.c.	Institution No.	Institution p.c.	Unsuitable Envir. No.	Unsuitable Envir. p.c.	Indep. Living No.	Indep. Living p.c.	Deceased No.	Deceased p.c.
0-6 mos: (N = 74)	56	75	9	12	7	10	2	3	0	0
7-12 mos: (N = 58)	49	85	2	4	4	7	3	5	0	0
13-18 mos: (N = 47)	39	83	2	4	1	2	5	11	0	0
19-24 mos: (N = 35)	26	74	0	0	1	3	7	20	1	3
25-30 mos: (N = 29)	24	83	0	0	1	4	4	14	0	0
31-36 mos: (N = 23)	18	78	0	0	2	9	3	13	0	0
37-+ mos: (N = 20)	9	45	0	0	2	10	8	40	1	5

For those who left the original foster home and did not move to another foster home, the first experience unfortunately resulted in the disabled client's choice of another type of living arrangement, which on the basis of our earlier definitions would be classified as a "negative environment." Since the family environments to which a number of the clients went or returned were generally evaluated as deleterious to the physical or mental health of the client, the practical necessity of accepting such living arrangements points to the need for

some type of continued guidance for the families and for the clients who do end up in these environments.

Additional information is provided by tracing the location of client cohorts at various time periods (see Table 2.9, page 75), for there is continual movement of clients into and out of the different living arrangements. On the basis of information about cohorts who have been in placement for longer periods of time, one would anticipate that approximately one-third of the population will remain in foster homes, while another 40 per cent will have returned to institutional or "negative" environments. About 25 per cent of the clients can be expected to move into their own apartments or homes for independent living.

Graduation Day

For clients with a potential for maintaining themselves independently in the community, a foster home placement may represent a period of transition and preparation. Our data indicate no optimal time for leaving the foster home for more independent living, for innumerable factors may influence the success of this venture. However, only a few of the clients were living independently before they had spent two years in placement.

VI. ENVIRONMENTAL CHANGES MADE BY CLIENTS

The success of the placement of a client in a foster home was dependent on many factors, not all of them directly attributable to the physical components of the home or to the qualities of the foster family. However, information about the changes made by clients provides some indication as to the

TABLE 2.9

LOCATION OF CLIENTS IN COHORTS ACCORDING TO TIME IN PLACEMENT AND PER CENT OF COHORT

Cohorts	Location*	Under 6 mos.	6 mos. - 1 yr.	1-2 years	2-3 years	3-4 years	4-5 years
Group 1:	F.H.	73	73	64	36	26	26
over 43 mos.	I.L.	0	0	0	9	19	19
(N = 11)	O.P.	27	27	36	55	55	55
Group 2:	F.H.	75	68	55	41	29	0
31-42 mos.	I.L.	4	8	8	17	29	0
(N = 24)	O.P.	21	24	37	42	42	0
Group 3:	F.H.	100	78	45	45	0	0
19-30 mos.	I.L.	0	0	22	22	0	0
(N = 9)	O.P.	0	22	33	33	0	0
Group 4:	F.H.	60	45	35	0	0	0
7-18 mos.	I.L.	10	10	10	0	0	0
(N = 20)	O.P.	30	45	55	0	0	0
Group 5:	F.H.	80	0	0	0	0	0
Under 6 mos.	I.L.	0	0	0	0	0	0
(N = 10)	O.P.	20	0	0	0	0	0

*F.H. = In foster home; I.L. = Moved to more independent living; O.P. = Out of the program, closed.

critical periods of greatest change. We have also included information about the destination of those clients who move from the foster home.

The First Weeks: Honeymoon Period

The first few weeks of placement often found the client and foster family on their best behavior. Both parties made attempts to go out of their way to please and to avoid any areas of conflict, because of a strong desire to make the match work. Clients were less demanding and the foster parents were willing to overlook aspects of the client's behavior which they

would ordinarily have found distasteful. This "honeymoon" period, however, did not last very long.

The First Six Months: Instability

The greatest period of instability occurred in the first six months of placement, as might have been expected. Approximately 25 per cent of the clients moved from their foster home, the majority of those moving out of the program entirely (see Table 2.8, page 73).

Reasons for Move from a Foster Home

There were general as well as particular reasons why a client did not remain in the foster home even after the most careful preparation of both client and foster family.

1. Initial reaction. If the clients had formerly lived in a home that was in a higher "social class" category, a change to a lower category was distasteful. This could include the cultural and social factors in the style of life pattern. Negro homes were rejected by white clients for this reason, as the clients held a stereotyped view of this group. This illustrated that disabled clients do not differ from the general population in their prejudices.

   Urban versus rural life was also a general problem. Some clients have become acclimated to the speed and variety of urban life, where crowds, stores and large buildings provide them with stimulating opportunities and they find it difficult to adjust their pace and interest to rural or suburban living. This is particularly a problem with the handicapped whose mobility is limited and who therefore cannot take advantage of suburban life which requires a high degree of mobility either by private or public transportation.

2. Particular problem areas. Most of the clients who moved from the foster home did so because of difficulties with the foster family. A list of the reasons provided by the SWs indicates that most of the moves were dictated by difficulties in interpersonal relationships in which the client was at fault. The major complaint of the foster mother was that the client was "too dependent or demanding." Some of the foster mothers also found that the client drank to excess or was verbally abusive.

The complaints were not one-sided. A number of the clients expressed their criticism, of the placement, although it was not often possible to check the validity of their complaints. The following factors were listed by about 50-70 per cent of the clients who moved. They are listed from greatest to least frequency of the complaints. Seventy per cent of the clients listed the first complaint:

a) Foster mother nags and argues a lot.
b) Friction over own family and friends visiting freely.
c) Food was unsatisfactory.
d) Problem over the use of the telephone.

Some of the other factors listed by the client were more a criticism of the environment or expression of generalized feelings of rejection. A number of clients felt that they were not accepted by the foster family and that they were in the home only because the family wanted the money that came with the client. Various clients complained of lack of privacy, no freedom to choose radio and TV programs and food not cooked to their own taste. Perhaps an even stronger sentiment that was expressed by a considerable number of the clients was their feeling that they were "isolated." These clients commented that they felt lonely because their friends did not visit them due to the distance from the central city. Others found the quiet suburban life too confining and lacking in stimulation. These clients felt somehow out of the mainstream of life. (There will be a comment in the later analysis on the reality of the criticisms.) However, in view of the limited mobility of the disabled, the satisfaction of a constant need for interpersonal contact does appear to be more possible for clients located in the heart of the city. This does not mean that the location of their residence will automatically obviate the loneliness they feel. Many of the disabled have expressed their feelings about the lonely walks amidst the hustle and bustle of the crowds on main thoroughfares and their deep loneliness while living in a crowded busy hotel.

VII. THE ROLE OF THE SOCIAL WORKER

Although the SW spent a lot of time in obtaining

services and intervening for the client, she also provided the disabled client with psychological counseling, an area perhaps more central to her role in the project.

In view of the absence of some norms to guide the social worker, each case was handled according to the needs as viewed by the SW. General goals for the clients, except the general one of keeping them in the community, were not set and each worker adopted the counseling approach that was most suited administratively to her style for the requirements of the case. It was obvious from an analysis of the approaches and the problems that arose that the caseworker found it difficult to decide on the best strategy and at times considered the client so impaired as to preclude any type of psychological counseling, except in a minimal way.

Counseling Procedures

The analysis of the counseling procedures required that we set up categories to provide the information about the type of counseling that had been used with the clients. The following categories were developed and they provide summary information about the type of counseling the clients received in the pre-placement stage: permissiveness, specific orientation, deeper SW involvement, specific areas of focus and degree of independent decision to the client was permitted (see Table 2.10, page 79). There is an elaboration of the categories and criteria for making judgments in the section which analyzes the findings of the study.

A summary of the counseling procedures and techniques used in the pre-placement period indicate the diversity of approaches that were felt necessary because of the wide range of personality types and needs, as well as the inclination for some of the SWs to follow their own style, based on their training and personality. In a later section, it will be shown that each social worker developed a counseling style that was generally used in some cases related to the type of client she was working with.

TABLE 2.10

PRE-PLACEMENT COUNSELING PROCEDURES
(N-74 = 100 Per Cent)

Counseling Procedure*	Per Cent
Orientation:	
Depth - analytical	24
Reality - pragmatic	76
Involvement:	
Intense	34
Moderate	49
Clinical	17
Area of Focus:	
All problem areas	28
Selected areas	49
Very limited numbers of problem areas	23
Degree of Independence:	
Client makes most decisions	23
Client and SW share in decision-making	73
SW makes most decisions	4

*See Chapter IV for elaboration of procedure.

A breakdown of the factors included in the areas of concern illustrates the range and scope of problems that the SWs had to concern themselves with. The SWs in this project were confronted with the task not only counseling the clients but also providing them with a large range of services and even going to great lengths to manipulate the environment to the client's advantage.

VIII. OBSTACLES TO PROVIDING THE CLIENT WITH MAXIMUM ASSISTANCE

It is an accepted fact that in may services providing counseling that each client should have a complete "workup."

Unfortunately this is not always possible in each agency, or when a client requests services. One of the key stumbling blocks in providing the client with more effective services was the lack of information about the client. The more information the SW had about the client's childhood background, education, vocational history, personality, functional limitations, intelligence and diagnosis given by others, the greater the opportunity for the SW to assess the possibilities for the client and intervene for him to his advantage.

Disabled clients are generally seen by many agencies, particularly if they have been disabled from childhood. It became apparent, in the ILP program however, that although the clients had been seen and worked with by other counselors at various agencies and institutions, the absence of any type of uniformity in record keeping and the difficult and time-consuming nature of obtaining information about the client's mental health and physical limitations from others meant that a lot of time and effort were wasted accumulating this information. In some cases where time was short the information was not available until the client had been seen by the SW for a considerable period of time, thus preventing maximum intervention at an earlier stage.

A second major stumbling block, related in many ways to the first condition, involved the absence of coordination and the lack of agreement as to role among the many persons providing services to the disabled client.

Although at the outset of the program there was contact among the heads of a number of agencies that were expected to be involved in the program, this type of coordination was not sufficient to offset the difficulties that arose. Disabled clients were confronted with many different agencies and personnel, each one serving a different need. To receive special welfare benefits, clients had to communicate not only with the social investigator but also with a special department with which the client was generally not familiar. If there was any possibility that the client could work, he went to the Department of Vocational Rehabilitation to discuss this with a DVR counselor. Any needed medical assistance required the client to contact a hospital or some rehabilitation agency. Should the client want to engage in recreational activities he would have to contact another agency and another social worker.

The disabled client's need for one specific person who would know his needs and background very well and who would intervene on his behalf with the multifarious agencies came into conflict with the traditional structure of scattered or decentralized services. Studies that have borne out the fact that the clients' ignorance of the mechanics of obtaining services and their inability to define their needs and problems underscore the necessity for one intervening agent.

Problems in Coordination of Services

The problems of the lack of coordination and the conflicts over roles were related to the multiplicity of services

available to the disabled. It was apparent from the outset that the innovating nature of this program had not permitted the development of an adequate structure to handle some of the ensuing problems. The Division of Vocational Rehabilitation was expected to provide the client with the appropriate vocational counseling and guidance and make arrangements for training. The caseworker of the New York Service for Orthopedically Handicapped was to counsel the client in all other areas that might affect his adjustment in the community. The following are some of the reasons for poor coordination service.

1. Although there was some coordination at the top level, there was no coordination or meeting of the counselors of the Department of Vocational Rehabilitation and the caseworkers of the NYSOH to discuss mutual problems. Unfortunately the pressure of time because of the large caseload of the DVR counselor often precluded contact between the two counselors. This frequently resulted in misunderstandings regarding clients who were emotionally wrought because of the inability to find training or a job. The DVR counselor did not realize at times the emotional turmoil present in the disabled client, because he did not work as closely with the client as did the caseworker of NYSOH. Naturally the caseworker was impatient with delays in vocational arrangements, although they may have been understandable, in the light of the procedures that have to be followed by DVR. The caseworker was working with the client as a type of "therapist" and thereby had a different view of him. In one case a client went into a severe depression because of what he felt was a lack of interest in his situation on the part of the DVR counselor. The client, however, was an "old case" and there were probably adequate reasons for the way the DVR counselor handled the case.

2. It is suggested that the DVR counselor has a "one factor" view of the client, with an emphasis on the vocational skills of the disabled client in view of his physical limitations. In many cases the client's total personality needs are not taken into account in the decisions made for him regarding employment. This approach, of course, could result from the different training or school of thought of the DVR counselor, and also from the realistic limitations of what he can do. The role of the DVR counselor in projects of this nature, particularly in his relationship to a caseworker who serves in effect, as a "central counselor" has to be defined more clearly.

3. The difficulty in placing many of our clients probably resulted in the caseworker's view of neglect by the DVR counselor and their comments that the counselor had only a superficial interest in many of the clients. Many of the ILP clients were severely disabled and could probably not receive training and be placed. However the caseworker could not make an adequate assessment of this situation because they were not familiar with the vocational possibilities available to the client.

Here is a brief account of a situation as reported by one of the project SWs.

"In the E case, I experienced delays and lack of coordination at the DVR which I feel was detrimental to my client.

"E was referred to DVR in November, 1963 for vocational counseling. He was not assigned to a vocational counselor until January, 1964 and could not get to see her until the end of February. During the one interview he subsequently had, it was decided that DVR would send him for a high school equivalency course. (Approximately five weeks at a cost of $30.00-$35.00.) If he passed the tests and received a diploma, he would be considered for business school or other training. The DVR counselor did not obtain approval from the supervisor for this course until April 21, 1964. Actually, if I had not called on the morning of April 20th to check on the progress of the case, it would still have been on the desk of the DVR supervisor. On that date when I insisted on speaking to the counselor's supervisor, the latter exclaimed that the new course began the next day, searched her desk for the E case, found it and agreed to send out a special delivery letter to the client to begin the next day (otherwise another five weeks would have gone by).

"I feel that these delays were not only disillusioning to the client but harmful in the casework process. E has experienced a great deal of rejection from adults in his environment. Although the foster home program has been a positive experience, he interpreted these delays as another indication of the adult world not caring. In addition, with casework help he has been motivated to move ahead, work and plan for his future. He experienced new hope in the ability to create a new life. When the objective environment could not keep pace with this growth, he experienced a great deal of frustration and then some return to his original lethargy."

CHAPTER III

ANALYSIS OF GENERAL FACTORS

"In a new Field, the formulation of meaningful problems is a task in itself--a task which often takes much time and effort. It is easy within an hour or two to state a hundred questions, in a few days to state many more. Yet only a few of these will prove to be fruitful. The selection of problems which are scientifically promising is an extensive qualitative research job. . . . There is also such a thing as premature quantification. That quantification which is done before the laborious task of qualitative description of problems and concepts is sufficiently advanced is premature. . . . Instead of regarding the statistical fact as an observation which needs anchoring in an explanatory system before its import can be judged, all too frequently such observations, by sheer virtue of their statistical nature, are held up as contributions in themselves. We do not declare that measurement should not be done without a well-developed theoretical framework but we do assert that such measurement often produces statistically significant differences on inessential details. We further assert that where problems well grounded in theory have not yet been formulated, data analysed qualitatively may contribute far more to the understanding of important problems." (Dembo in "Adjustment to Misfortune.")

I. METHODOLOGY

The nature of a research-demonstration project is somewhat ambiguous in that the objectives of demonstrations frequently do not become clarified until the project has been underway for a period of time. In the Independent Living Project, there were modifications and clarifications of the objectives, and the criteria for measuring them, throughout the first three years. The broad nature of the project presented a number of problems with respect to analysis and

evaluation, but also provided an opportunity for the inclusion of information that focused on an area larger than originally envisioned at the inception of the study.

Introduction

The broad scale attack on a problem, permitting the social worker to manipulate the environment as well as counsel the client, has been suggested as the most effective approach for bringing about desired change. In a recent study the authors noted that:

> "It would seem appropriate to point change efforts towards conditions directly affecting situations determining these outcomes as well as toward changes in the clients themselves. If multi-level attacks are to be utilized, models of service programs, or some combination of these models, can be suggested. Each social worker might seek to operate at various levels, from psychological influences through manipulations of interpersonal and environmental conditions. Or various agencies might seek to coordinate efforts at various levels on behalf of the clients, constructing a comprehensive plan for achieving change."[1]

The small number of clients in the program did not allow for the more detailed type of evaluation that would have been preferred. The conclusions are based on a statistical analysis which did not include controlling for the many variables that might have affected the results. The attempt was rather to impose some structure on the problem and through a series of hypotheses to analyze the data and present the results. In many cases the results were supported by qualitative material that was available. If the conclusions are viewed in this light then perhaps they can add to the store of information on the factors affecting the adjustment of the physically disabled adult in the community and provide useful leads for others engaged in this type of research.

Purpose of Evaluation

The purpose of the evaluation was to determine the effects of:

1. foster home placement and
2. social work intervention

in:

1. maintaining clients in the community at a level "commensurate with intake," and
2. affecting their progress or advances in the vocational and interpersonal areas

on two groups of orthopedically disabled persons:

1. those who were occupying hospital beds although not in need of hospital care, but could not be discharged because there were no suitable living accommodations in the community, and
2. those who were living in the community but who might deteriorate if they continue living in their "negative environments" and would probably be institutionalized.

Although the foster home and the intervention of the social worker were initially considered as the major variables affecting the client's success in the community, it became clear as the program went on that other major variables may have played a role in the adjustment of the clients to the community, offsetting the efforts of the social workers and the type of placement made for the client. In effect, data were gathered on the adjustment of the disabled clients in the community and then there was an attempt to locate the variables that contributed to their success or failure. Specifically, this study is an investigation of the outcome of placing the orthopedically disabled person in a new environment in an urban community through intensive social work intervention. It is primarily directed at understanding the factors that permit some disabled to remain in the community and make advances in many areas of social functioning, while others deteriorate mentally or have to return to the institution.

II. RESEARCH DESIGN

The ideal in a research project is to follow the scientific model and use both an experimental and a control group. All to frequently, the use of this particular design is devoid of any real meaning with respect to the factors that are being evaluated or measured.[2]

Control Groups

To evaluate programs where factors that are to be evaluated cannot be specified in detail, or where there is the possibility of a host of other factors affecting the outcome, involves the expenditure of enormous time and energy and produces results of dubious or limited value.

Demonstration projects such as the ILP, furthermore, focus on areas in which there is not yet sufficient differentiation of potentially important variables to permit the establishment of a control group. Additional factors that are probably relevant to many other similar projects precluded use of a control group:

1. The ethical problem of having to deny services to some of the physically disabled adults.

2. The fact that many foster families accepted the disabled only because they knew that the agency was ready to assume responsibility at any time.

In addition to the factors already listed, the broad scope of the project including the diversity of clients and services they were to receive and the variety of settings in which they were to be placed, precluded the possibility of using control and experimental groups.

Contrast and Comparison Groups

Although contrast or comparison groups do not provide a scientific evaluation of services being given, they do shed some light on factors affecting the clients' success or failure.

Two such populations became available during the course of the project, and were followed up in an attempt to gain information about their life in the community:

1. One group (to be referred to as the CONTACT GROUP) was composed of disabled persons who had at one time been in touch with the agency but had either refused the program offered or had made other plans prior to acceptance. Only a small percentage of this group responded to our inquiries. However, the information obtained from this group was included in the analysis.

   An attempt to obtain information from this group by mailing them questionnaires resulted in only a 10 per cent response which did not allow for extensive comparisons. Interviews with these

disabled individuals would have permitted the results of the program to be placed in the proper perspective but costs and time did not permit this type of follow-up.

2. The second group did not come to our attention until the final year of the program. Through the lack of communication or misunderstanding (a recurrent theme everywhere) the research director was not aware until the final year of the project of the placement of many clients in foster homes by the Department of Welfare. This program was apparently not instituted until the ILP program had been in existence for two years. However, upon learning about this group, general information was requested from the Department of Welfare about these clients. The Department was magnanimous in its response and we were able to make some gross comparisons of the groups.

III. POPULATION

The population that was to be included in the ILP was expected to meet the following criteria:

1. Type of disability. Clients who were considered for the program were expected to have a significant skeletal or muscular impairment, regardless of time of onset.

2. Medical status (for institutional group). Clients who no longer needed active medical or nursing care in the hospital were accepted so long as any medical care they did require could be supplied on an outpatient basis.

3. Age. Only clients above the age of 18 were considered, with an upper limit set at about 40 years (some exceptions were to be made when the patients were judged to have good potential).

4. Other general criteria. Disabled persons who were suffering from severe mental retardation or emotional disorders were to be excluded from the program. To be eligible for the program, the potential client had to have the proper motivation and express the desire for more independent living. In the case of institutionalized persons, the

hospitals had to agree to re-admit the patients should the client be unable to remain in the community.

5. Vocational objective. Potential clients did not have to exhibit an immediate vocational potential although it was expected that as a result of this program, many would be able to undertake vocational training and find employment either in competitive industry or in a workshop setting.

Source of Referrals

Patients were referred to the ILP by hospitals, nursing homes, custodial institutions, and community facilities serving the handicapped, such as the Division of Vocational Rehabilitation, the Division of Special Placement of New York State Employment Service, the Department of Welfare, and out-patient departments of hospitals. The referring institution completed a detailed referral form (see Appendix) developed by the project which contained relevant medical, psychological and social information for each patient. Following the evaluation of this information, conferences with workers from the referring agency, and consultation with outside specialists, the project staff determined whether or not the patient was eligible for this service on the basis of the criteria described earlier.

IV. CRITERIA FOR EVALUATING THE SUCCESS OF THE PROGRAM

The initial criterion which was suggested as the measure of "success" of the program was that the client "remain in the community at a level commensurate with intake." In setting up the operational indicators, it became apparent that return to the institution was not the sole factor that would justify classifying the client as a "failure." After a small group of the clients had been in placement for a short period of time, it became evident that other criteria of "failure" had to be specified, particularly in keeping with

the definition that the clients do not deteriorate further from the level maintained at the time of placement. There would be little purpose in placing clients in a "new environment" in the community and providing them with social work services only to have them deteriorate mentally or physically. Although the prime consideration in the research perspective was to identify the factors that would prevent the client from becoming institutionalized or deteriorating, it was anticipated that clients would move to a higher level of social functioning.

Placing the client in a "positive environment with a family that was to serve as a nexus for community living" and providing him with casework services should, it was felt, enable the client to attain a higher level of occupational and social functioning.

Criteria for Client Failure

The following criteria was used to classify the "failure" of the clients:

1. Institutionalization. The client returns to the hospital, or is hospitalized on a permanent basis.

   (Clients who were suffering from a progressive disease and who were hospitalized for this ailment could not be classified as unsuccessful in that failure was not due to any factor related to community life, that is, there were no arrangements in the community that could have prevented the deterioration.

   (If the client were forced to return to the hospital because of situations beyond his control, such as:

   - death in the foster family

- moving of the foster family to another city

the client was not classified as a failure.

(Temporary hospitalization of a nature that might normally occur among the non-disabled or were for the purpose of further rehabilitation or adjustments related to the disability were not considered as failure.)

2. Mental deterioration. There were behavioral indicators which by their nature could be accepted as evidence of mental deterioration. These included:

   - suicide
   - placement for any length of time in a psychiatric ward
   - imprisonment for any offense
   - a report by the ILP social worker regarding client's mental deterioration.

3. Return to "unsuitable environment" in the community. Approximately 50 per cent of the clients in the ILP came from environments in the community which were considered to be detrimental to their mental health. It was expected that if these conditions continued, they would eventually deteriorate and require some type of institutional care.

   Clients who dropped out of the program by leaving the foster homes and moving back into their previous "environments" or to similar "unsuitable environments" were classified as "unsuccessful." In view of the original assumption regarding their eventual deterioration in those environments, this classification as "failure" appeared warranted.

4. Excessive mobility. Clients who moved more than three times a year were evaluated as showing evidence of "high instability." It became readily apparent that this group could not settle down and would probably end up in an institution immediately after losing the support of the caseworker's intensive services. We were able to demonstrate that this "excessive mobility" was also related to "mental deterioration" and an unsatisfactory adjustment. Clients who were hospitalized at least five times a year for conditions unrelated to their disability were also included in this category.

Performance in the Community

Measures of improved social and occupational functioning in the community are value judgments. They are based on the premise that scores indicating upward movements on specific scales are related to positive physical or mental health and provide evidence that certain of the human needs of the disabled client are being met.

Each of the factors was scored relative to the client's initial score upon entering the program.

The major variables were:

1. Physical condition. A measure of the improvement in the client's general state of health, as indicated by frequency of illness and need for medical care, and the client's view of the state of his health.

2. Vocational advances. A measure of the client's employment record.

3. Interpersonal affiliation. A measure of the client's involvement with family, friends and people in general including participation in activities with others.

4. Quality of living. A measure of increase in the client's utilization of community facilities and qualitative elements of daily living.

5. Mental health. A measure of the client's movement in the direction of behavior classified as positive mental health, or improved personality organization.

V. RESEARCH INSTRUMENTS

The range of factors that could have contributed to the successful adjustment of the clients in the community required the accumulation of substantial information about the client and the process of adjustment. Many types of research instruments, both quantitative and qualitative, had to be employed, inasmuch as the few standardized tests

available were not sufficient for the task.

The research instruments, and the data collection procedures and problems are discussed in a separate section. Apart from the individual tests and inventories, the voluminous case records of the social workers were used in the analysis to substantiate some of the results, or to provide some of the "missing links" in the research process.

Limitations

Some of the disabled were unable (because of a manual disability) to complete the forms, and alternate methods had to be used to obtain the information from them. Others were tired of personality tests, having been exposed to them for many years. For example, when returning a research questionnaire, one client commented to her SW that she wished she were not crippled, and that the questionnaire reminded her that she is crippled "because it comes from an agency for the handicapped."

In certain cases, the foster parents had language difficulties, and in a number of other cases refused to complete questionnaires and tests because they felt their privacy was being invaded. In all of these situations, alternate methods were used, and the clients were not pressed to complete the tests.

Descriptive Information and Measures of Behavioral Functioning: Clients

The ILP clients are described by use of the following instrument:*

1. Background data schedule. In view of the strong possibility that the client's childhood and history might play a role in determining his adjustment to a new environment, extensive data in these areas were collected. Information about the client's family and childhood history was obtained from the

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*As the present research director did not join the project staff until the program had been underway for a year, it was not possible to obtain baseline data on all of the clients who were placed in the first period.

casework records of our social workers and from the records of other agencies that had worked with the client, particularly the institution from which he came.

Data on socio-demographic characteristics were obtained directly from the client on standardized forms or from interviews.

2. Physical aspects. A medical report was sent to institutions for the physicians to complete; however, the physicians were unable to complete most of these forms, particularly for clients who did not come into the program directly from a hospital. Thus, it was necessary to rely upon medical abstracts obtained from the institutions in which the clients had last been treated and on interviews with medical and social workers.

   Although the absence of specific medical data on the client's physical condition left a partial gap in the ability to measure his degree of physical deterioration in the community, it is felt that because of the broad-scale nature of the study, this information would not have materially aided in reaching any meaningful conclusions. An additional measure, which was designed to provide a detailed picture of the effect of the functional abilities of the clients in their activities of daily living, was filled out by the SWs. It included information about the client's appearance and served as a baseline for judging improvements in this area. In this study, an attempt was made to locate the global factors that might have played a role in the adjustment of the client in the community.

3. Vocational history. Information about the client's training, skills and experiences in the vocational sphere was compiled. This information was used as baseline data in the measurement of changes.

4. Style of life. Information about the client's habits and tastes, and his "style of life," was obtained from the client, and in some cases from his family or another social worker.

5. Personality tests. Most of the clients completed a battery of tests that included the MMPI, Edwards Personal Preference Scale, and the "F" and "T" tests. Unfortunately, not all of this information could be used because of insufficient time in

which to process the inconsistency of response in some of the tests making the total scores meaningless.

6. General advances: Health and interpersonal relations. Information about the client's general perception of his health, at the outset and at intervals during his period of placement, was compiled in "an Interval Health History" report form. Data on interpersonal relations, focusing on interaction with others were also obtained from the client.

7. Mental health. The SWs reported periodically on the client's mental health on a Personality Factors Change Schedule (see Appendix). These schedules were filled out when clients first entered the program after having been interviewed at some length by the social workers. Using this schedule, the case workers reported on the client's mental health at regular intervals whereby the processes of adaptation or deterioration could be followed. When a crisis arose, the SW filled out the schedule, noting the client's state of personality organization during the crisis period. The schedule required only global judgments on various personality factors.

Two research assistants perused the case records to find evidence for the judgments made by the case workers, and thereby provided an independent verification of the scores given the clients.

To provide the SWs with a framework for using the schedule, conferences with the SWs were held prior to its use. They were given an explanation of the possible ways in which they should view the description of the personality characteristics and there was an attempt to arrive at agreement on the definitions of the personality factors listed.

Although there are a number of personality evaluation schedules available, a different global rating scale was necessary for this project. The major objective was to measure the degree of functional impairment of the client, based on a simplified scale suggested by a number of personality theoreticians and researchers.[3] It was expected it would not be possible to determine slight changes in the behavior of the client. The extreme forms of deterioration that prevented the client from functioning in the community was important,

however, either in the guise of complete withdrawal and vegetation, or in harmful and destructive behavior to himself or to others.

8. Physical health - medical care. The measurement of physical deterioration was simpler in some ways, more difficult in others. It was not possible to set up a medical evaluation system utilizing either several medical consultants for periodic checkups or even one medical diagnostician.

   The evaluation of the client's physical health was made on the basis of any deviations from his state of health upon entrance into the program. Information for this baseline data was obtained through medical abstracts or from interviews with medical personnel. When a client was seen by a physician or was placed in a hospital, a report was completed by the appropriate personnel providing us with information regarding the reason for the hospitalization or the medical care given. This provided us with a global measure of change in the client's physical health.

9. "Functional Activities Index." A detailed inventory, listing the client's functional limitations in daily activities, was completed by the SW. When the client entered the program, the SW was requested to note any significant changes and in a number of cases the Index was completed again after a year. Changes of a minor nature may have occurred. For example, a client may have learned how to walk longer distances. However, it was not always possible for the SW to pick up all of these changes, although an additional attempt to detect such changes was made when the case records were read by research assistants.[4]

Descriptive Information: Foster Family and Physical Environment

Extensive information about the foster families' homes (both household design and functioning), the neighborhood and the community was to have been collected on uniform schedules by the project homefinders.* Qualitative descriptions about

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*Most of the homes were located during the first year of the program. The current research director was not present at the time and the forms used were not complete, or were incorrectly filled out. It was not possible in all cases to obtain the information at a later date.

the family were obtained by the homefinders and social workers in addition to those obtained on standardized forms. Additional information was collected on the "style of life" of the family and the personality attributes of the foster mother.

Socio-demographic information about the foster family and the general attitude of members of the family towards the program were also obtained at the time the family was accepted for the program.

Information About the Process of Adjustment

To gain further insight into the process of the client's adjustment, a detailed analysis of the casework records was made. The SWs were also interviewed at regular intervals in the attempt to uncover patterns in the "adjustment process."

"Environmental Change Form"

Every environmental change (that is, movement from the foster home) was recorded by the SW together with a list of the reasons for the change as expressed by the foster parents, the client, and the SW.

Establishment of Time Intervals for Evaluation

The nature of this research demonstration project required that clients enter the program at intervals in the duration of the program, that is, a specified number entered at the inception of the program and a number of additional clients was expected to enter during each subsequent year. This procedure meant that clients would have been in the program for varying lengths of time at the conclusion of the program and therefore it was necessary to establish individual time intervals for evaluation.

This staggered intake of clients was necessary to allow the social work staff a reasonable amount of time in which to assess each client's needs and to prepare him and the foster family for the placement. The entrance of clients into the program throughout the four placement years of the project was beneficial to the research process in some respects, but harmful in others. It allowed the research staff to introduce changes in measurement and procedures before most of the clients were in placement. Unfortunately, it also presented a number of problems in the evaluation of the program.

Foremost among the problems was the need to arrive at conclusions about the success and failure of clients who at the cut-off date had only been in placement for about six months. In the discussion of the in-placement results, mention

has been made of time periods used in the analysis. It was possible to evaluate one group which had been in placement for two years. However, the data did not allow a two-year prediction of the situation of clients who had been in the project for a shorter period of time.

VI. FRAMEWORK OF ANALYSIS

An initial analysis of the factors that would differentiate the successful group from the group of clients that failed focused on such general factors as type of disability, age, sex, race (see Table 3.1, page 101).

Following this analysis, several hypotheses that had been developed during the early stages of the program were tested. The analysis employed statistical techniques appropriate to the limitations imposed by the type of data available. Although this type of analysis presents many problems, it was more meaningful to adhere to its requirements than to attempt the use of more sophisticated statistical techniques. Where data could be more readily quantified, other statistical techniques were employed. This method did not, of course, allow for the type of predictions that would have made the study more useful.

Adding to the validation of some of the major hypotheses, however, was a body of qualitative data. The conclusions, therefore, should be viewed as tentative in the light of the small size of the population, its heterogeneity, and the type of statistical analysis that was performed. The intent of the analysis was to encourage explorations along similar lines and to be of some heuristic value.

The next stage of the analysis was designed to determine if services by the social workers, or the type of foster home in which the client had been placed, were directly related to their success or failure. It was possible that the clients' success might have been the result of the social work services, the clients' ability to find work, and placement in a suitable foster home. Again, because of the small number of clients, the heterogeneity of the client population in socio-demographic and disability characteristics, the heterogeneity of the foster family population and of the services provided by the SWs, no way was found to arrive at any meaningful method of determining the weight of all of these interacting variables. There was an attempt, however, to determine the major factors that appeared to contribute to success and failure, by controlling for some of the variables while testing our hypotheses.

Theoretical Framework

Although the project was not started with an elaborately designed theory on which to base the predictions of success or failure in the program, it was later seen during the program that certain factors were operating that could be formulated into hypotheses.

It became apparent that the clients had varied needs and that the strengths of these needs differed in intensity. Some clients appeared to be willing to exert all of their energies to find employment, while others were content to sit in their foster homes making occasional forays into the world. The experiences of the clients affected them quite differently and the results of these experiences led to differing behavior patterns. These views, of course, merely express a truism that disabled clients have different needs and vary in their reactions to frustrations and their ability to meet their needs in whatever manner.

Although the central needs of all of the clients could not be identified and certainly not the intensity of the varied needs, it was possible to arrive at certain hypotheses, and to obtain some measures of the intensity of the needs. In the assumptions some broad generalizations were made; however, these were based on the observation of the client's functioning over many months.

The first basic assumption was that severity of disability interferes with the individual's ability to meet most of his needs and that it was possible that more of the client's needs might actually be met in the institution. It was therefore hypothesized that the more severely disabled would be more severely affected in being unable to meet their needs and would return to the institution or deteriorate. This view was not borne out. It was then thought that perhaps severity was not actually a factor because the severely disabled had lowered their expectation level and would actually not be as adversely affected when their needs were not met as would the adults who still retained their needs at a high strength level. It was, however, found that severity of disability did not necessarily decrease the intensity of the needs of the clients, nor apparently did a childhood that included physical and psychological deprivation.

On further analysis, it appeared that the need to fulfill a social role, particularly that of working, was an important need for many of the clients. It was therefore hypothesized that the failure to fulfill this role would lead to the client's failure, particularly so for the males for whom society has set up certain expectations regarding this role. This was found to be the case, and inasmuch as we had certain measures of the intensity of the need for achievement that was related to this particular need for a number of clients, this hypothesis was also tested and found to be true. Females in the program who fulfilled roles that were more closely related to that of homemaker, or who were better educated and were able to exercise a wider repertoire of skills in achieving satisfaction, were also more successful.

Although our hypotheses were somewhat general, they were included to provide some structure to the analysis and possibly prove to be of some heuristic value for other researchers.

Socio-demographic Factors

Factors such as education, place of birth, race, sex, age, and previous occupational pattern did not appear to contribute directly to success or failure (see Table 3.1, page 101). Although the relationship was not statistically significant, there was a higher proportion of successful clients among those clients who had not graduated from high school. In addition, the proportion of unsuccessful males was quite

TABLE 3.1

SOCIO-DEMOGRAPHIC FACTORS IN RELATION TO SUCCESS AND FAILURE IN PLACEMENT

Factor	Successful (N-43 = 100%)	Unsuccessful (N-31 = 100%)
Education:		
High School Graduate	35	52
Did not graduate or attend high school	65	48
Birthplace:		
New York City (native resident)	60	61
Outside of New York City	40	39
Race:		
White	84	81
Negro, Puerto Rican	16	19
Sex:		
Male	49	61
Female	51	39
Work History:		
None	35	19
Worked at sometime prior to placement	65	81
Origin:		
Hospital setting	49	51
Unsuitable environment in community	51	49

high, constituting 61 per cent of all unsuccessful clients. It is of interest to note that the proportion of failures was about the same for clients who had come from a hospital as for those from "unsuitable" environments in the community.

Severity of Disability

It was anticipated that clients who had minor physical disabilities would remain in the community longer than the more severely disabled clients.

The criteria for classifying the clients according to severity of disability are described in Table 3.2 below.

TABLE 3.2

CRITERIA FOR LEVELS OF SEVERITY OF DISABILITY
(N = 74)

Level	N	Wheel-chair Bound	Poor Arm Control	Speech Diffi-culty	Needs assistance in areas of Personal Care 1, 2, 3, 4, 5*
I	4	X	X	X	any one
II	10	-	X	X	none
		X	-	X	any one
		-	X	X	any one
		X	X	-	any one
III	13	X	-	-	any one
		X	-	-	none
IV	7	-	X	-	any one
		-	X	-	none
V	19	-	-	-	any one
VI	20	-	-	-	none

*1 = eating; 2 = bathing; 3 = toileting; 4 = grooming; 5 = dressing.

The hierarchy of levels used in the scale was based on the types of disability that limited the clients' mobility, and interfered with satisfactory interpersonal relationships and the ability to work. The scale also included such factors as appearance, ability to communicate with others, and the need for personal assistance in eating, bathing, toileting, grooming, and dressing that could be expected to interfere with the clients' social and occupational functioning.

The rationale for the scale[5] is as follows:

1. Wheelchair bound clients could have
   a) difficulty in obtaining employment;
   b) transportation problem;
   c) poor mobility;
   d) need for assistance in personal care.

2. Clients with poor arm control would have
   a) difficulty in obtaining employment where a basic requirement is reasonable manual dexterity;
   b) probable need for greater assistance in personal care.

3. Speech difficulty would interfere with the ability to establish satisfactory interpersonal relations and would effect the adjustment on the job or in the foster home.

4. Need for personal assistance could have an effect on employability or on foster home adjustment due to excessive demands on the personnel or the family.

The assumption that the less disabled would meet with success was not borne out.[6] This initial assumption was based on the belief expressed by workers in the rehabilitation field that clients with the disabilities listed at the top of the scale would be unable to sustain themselves in the community and would find community living too much to cope with (particularly as compared with hospital living). The results (as shown in Table 3.3, page 104) show that the more severely physically disabled were actually more successful. Twice as many clients in Levels V and VI were unsuccessful when compared with those in Levels I to IV.

Analysis of Physical Components and Success

A further breakdown of the factors related to the physical condition of the client and their association with success was performed (see Table 3.4, page 104). The results reinforced the findings with respect to level of severity and success.

Clients who were wheelchair bound were found to have been significantly more successful, although it was the female population which contributed to the level of significance in the overall comparison. Male clients whose general appearance was classified as "Awkward" were significantly more successful than male clients who had been classified as "Attractive." This result was unexpected in that it has heretofore been

TABLE 3.3

DISTRIBUTION OF ILP CLIENTS ACCORDING TO RELATION OF SEVERITY OF DISABILITY TO SUCCESS IN PLACEMENT (N-74 = 100 Per Cent)

Level of Severity	Successful No.	Successful Per Cent	Unsuccessful No.	Unsuccessful Per Cent	X^2	P
Dichotomized:					4.8	.05
I - IV	25	34	10	14		
V - VI	18	24	21	28		
Trichotomized:					6.65 (df=2)	.05
I - II	10	14	5	7		
III - IV	15	20	5	7		
V - VI	18	24	21	28		

TABLE 3.4

FACTORS RELATED TO DISABILITY AND SUCCESS IN PLACEMENT

Disability	Per Cent Success	100 p.c. Equals	Per Cent Unsuccessful	100 p.c. Equals	ro
Wheelchair-bound	40	43	13	31	.29*
Male	20	21	20	19	NS
Female	55	22	8	12	.45*
Cerebral Palsied	42	43	35	31	NS
Male	43	21	32	19	NS
Female	41	22	42	12	NS
Attractive appearance	49	43	61	31	NS
Male	42	21	73	19	.31*
Female	54	22	42	12	NS

*p .05

noted that there is a relationship between the public acceptance of the physically disabled person and the disabled individual's appearance. The classification of the clients as "Attractive" or "Awkward" was based on judgments made by the social workers, who drew upon their knowledge of the public attitude toward various types of disabilities.

Age of Onset

One highly significant difference with regard to success or failure was found between clients who were disabled before the age of ten and those disabled after this age (see Table 3.5, below). No significant difference, however, was found between the congenitally disabled and the acquired disability population. A possible explanation for this finding can be found in most theories of personality development that have stressed the influence of the early years of life on the formation of personality characteristics found in childhood. It is therefore quite possible that the acquisition of the handicap before the age of ten allowed the disabled clients to work out a pattern of adjustment that was responsible for their success in the community. The "acquired handicap" group would have had to work out a new pattern of adjustment and as a result, may have found it more difficult to adjust in the community. This finding will be discussed and analyzed more fully in the next section.

TABLE 3.5

AGE OF ONSET OF DISABILITY
AND SUCCESS IN PLACEMENT

Age of Onset	Per Cent Success	100 p.c. Equals	Per Cent Unsuccessful	100 p.c. Equals	ro
Under age 10:	70	43	35	31	.34**
Male	67	21	32	19	.35*
Female	74	22	25	12	.38*
Congenital:	51	43	32	31	NS
Male	47	21	26	19	NS
Female	54	22	42	12	NS

*P .05; **P .01

Psychopathology

To eliminate the possibility that the unsuccessful clients were those who would have shown a high level of personality disorganization upon entering the program (that is, were emotionally disturbed at the outset, and found it more difficult to adjust because they followed their pre-placement pattern of deviant behavior, rebellion, aggression dependency or withdrawal), they were compared for initial level of psychopathology and success. High levels of personality disorganization may have vitiated any effects of the counseling which these clients received. In testing this factor, no significant difference was found on the initial scores of the successful and unsuccessful groups on the Personality Factors Change Schedule (PFCS). (See Table 3.6.)

TABLE 3.6

RELATION BETWEEN PSYCHOPATHOLOGY
AND SUCCESS IN PLACEMENT
(N = 74)

Group	N	PFCS Mean	SD
Successful	43	20.4	5
Unsuccessful	31	21.9	5.1

t = 1.2; P .25.

Information on the clients' pre-placement personality status was obtained by another researcher using a scale similar to the PFCS (which had been completed by the SWs) with the results shown in Table 3.7 (page 107).

This added confirmation would indicate that personality disorganization at time of placement can be ruled out as the basic cause of the failure of the clients.

Clients' Needs and Their Relationship to Community Adjustment

In the analysis of the factors that may have contributed to the success or failure of the clients in the ILP, the major emphasis was on the relationship between a client's central

TABLE 3.7

RELATION BETWEEN PRE-PLACEMENT PERSONALITY STATUS AND SUCCESS IN PLACEMENT (N = 74)

Group	N	Mean	SD
Successful	43	17.8	2.8
Unsuccessful	31	17.1	5.1

t = .75; P .42.

needs and the degree to which they were blocked. The general views expounded upon have been outlined by other researchers who have noted that "Needs exist at varying levels of centrality in the organism's psychic economy. Some are all-consuming and powerful; others are peripheral and evanescent."[7] There are significant individual differences in the hierarchical structure of the needs systems of different individuals. Achievement, sexual or affiliative needs may occupy a prominent and central position in one individual's need economy and a rather peripheral one in another's. In this view, the stronger the need which is being thwarted by a particular stressor event, the more intense is the state of stress likely to be.

The broad-scale nature of the ILP did not permit us to examine carefully the relationships of the individual's central needs to the conditions and situations in which he found himself during his stay in the community. Rather, certain assumptions were posited, and the data were examined for these relationships. The first assumption was that clients who had been disabled from childhood had lowered their expectation level and were not affected by the many frustrations they had had to face. Those who had been disabled later in life, on the other hand, maintained a high expectation level for fulfilling their needs.

The next assumption posited was that males, in particular, had a strong (and probably central) need to work. Interference with this need would probably create great stress when extended over a period of time, and eventually result in personality disorganization, requiring removal of the client from the foster home. Finally, an attempt was made to relate a specific indicator of the "need for achievement" with the client's fate in the community.

VII. HYPOTHESES

In predicting results of this study, two hypotheses were put forth regarding pre-placement deprivation and need expectation and achievement.

Pre-Placement Deprivation and Success

The first hypothesis focused on the relationship between the client's experiences prior to placement, and his success after placement. It was hypothesized that:

Hypothesis 1: Clients who had had a deprived childhood would be more successful in remaining in the community than those clients who had suffered relatively less deprivation.

This hypothesis was based on the belief that clients who had gone through a lifetime of deprivation would make fewer demands and adapt themselves more readily to less satisfactory living conditions. On the basis of information gleaned from socio-demographic statistics, it was predicated that clients with a history of early deprivation would have lower expectations regarding work and family. Furthermore, they would accept community living without fulfillment in these areas and would not show signs of personality disorganization because of the absence of such fulfillment.

The individual indicators of the client's deprivation were first grouped into five categories, and clients who fell into at least three of the five categories were classified as "deprived." In some cases, the indices subsumed under the category, "broken home," were further refined, and clients received higher scores if the combination of factors under this heading indicated unusually severe deprivation.

The factors included under the general classification, "deprived," were the following:

- broken home;
- onset of disability before age 10;
- low education level, that is, did not graduate from high school;
- never worked prior to placement;
- deficient in interpersonal relations.

In view of the possible relationship between deprivation and success, a statistical analysis of the clients' background,

(that is, deprived versus non-deprived) and their success or failure was performed (see Table 3.8, below).

TABLE 3.8

RELATION BETWEEN PRE-PLACEMENT BACKGROUND AND SUCCESS IN PLACEMENT (N = 74)

Background	Successful		Unsuccessful	
	No.	Per Cent	No.	Per Cent
Deprived	29	39	15	20
Non-deprived	14	19	16	22

$X^2 = 2.7$; N.S.

Need Expectation and Success

The second hypothesis was based on a general picture of the factors that interfered with adjustment or movement in the community.

Hypothesis 2: The client's ability or willingness to remain in a positive environment in the community without engaging in deviant behavior or suffering from psychological deterioration is a function of the degree to which the central need expectations and aspirations of the client are blocked.

Thus it appeared, for example, that clients who had been disabled through an accident, but who had a relatively good education and whose general life pattern lay within normal bounds, had high expectations with regard to fulfilling the social and occupational roles normally expected of them.

The next step was to establish a set of indicators which would classify clients according to their needs and expectations. Although a number of specific measures which represented more direct expressions of clients' needs had been collected, the first analysis assumed that all of the clients had a "high need" to work.

Work and Success

The hypothesis regarding blocked aspirations and failure focused primarily in an area of central concern to the clients, namely, work. The assumption was made that work was an important need of the group. This was particularly true for the male clients. This assumption was based on the following rationale.

The importance of work in the United States society cannot be sufficiently stressed, despite the major revolutions in the introduction of automation and other labor-saving devices that are today altering the thinking about the necessity for everyone to work. For the handicapped person, the elimination of the need for physical labor in many jobs only increases his desire to participate in the world of work. As some authors have commented, "Perhaps the role most consistently expected of adults in urban American settings is instrumental performance with respect to work."[8]

In the evaluation of the progress made by the clients in occupational functioning, all of the work activities of the clients were listed, and then analyzed to ascertain if there was a relationship between work and the client's success in the community. The results are broken down according to the sex of the client, since the differing expectations held by society for the male in the world of work become the culturally built-in expectations that the male will hold for himself.

Since a wide variety of definitions for work had been included, it was expected that all or most of the clients could be said to have found work. The results showed that even the most severely disabled were represented in the working group* (see Table 3.9, page 111). (Partially responsible for this finding, however, was the fact that workshop employment was considered as "working during placement," and that many CP's were so employed.) Nor was intelligence a discriminating factor, since nearly half of our male clients classified at the "dull" intelligence level had worked at some time while in placement (see Table 3.10, page 112).

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*Our indicators classifying the client as "having worked" included any type of work performed by the client. This was based on the view that the more severely handicapped who worked at home or in workshops could still see themselves as fulfilling a role prescribed by society.

TABLE 3.9

DISTRIBUTION OF MALE CLIENTS ACCORDING TO WORK HISTORY AND GENERAL FACTORS (N-40 = 100 Per Cent)

Factor	Work No.	Work Per Cent	No Work No.	No Work Per Cent	Total No.
Age:					
18 - 25	6	55	5	45	11
26 - 30	4	67	2	33	6
31 - 40	4	44	5	56	9
41 - plus	6	43	8	57	14
Education:					
H.S. Grad. +	9	50	9	50	18
Less than H.S. Grad.	11	50	11	50	22
Race:					
White	16	52	15	48	31
Non-White	4	44	5	55	9
Disability:					
Cerebral Palsy	10	56	8	44	18
Non-Cerebral Palsy	10	46	12	54	22
Time of Onset:					
Before Age 13	13	62	8	36	21
After Age 13	7	37	12	63	19
Appearance:					
Attractive	11	48	12	52	23
Awkward	9	53	8	47	17
Eating:					
Independent	15	52	14	48	29
Needs Help	5	45	6	55	11
Bathing:					
Independent	17	55	14	45	31
Needs Help	3	33	6	67	9
Toileting:					
Independent	15	54	13	46	28
Needs Help	5	42	7	58	12
Dressing:					
Independent	16	55	13	45	29
Needs Help	4	36	7	64	11
Mobility:					
Wheelchair Bound	3	38	5	62	8
Ambulatory	17	53	15	47	32

TABLE 3.10

RELATION OF WORK HISTORY AND INTELLIGENCE LEVEL OF MALE CLIENTS (N = 40)

Intelligence Level	Work	Non-work
High	6	3
Normal	10	12
Dull	4	5
Total	20	20

Inasmuch as the males were the major focus of attention in searching for the efforts of work on client success, the distribution of types of clients who worked is presented for the male group only.

An analysis of the data (see Table 3.11, page 113) strongly supports the relationship between success and work at some time during the course of placement. The results show that there is a highly significant difference between the successful and the unsuccessful groups, depending upon whether or not they were employed. Approximately 40 per cent of the male clients who were employed at some time during their placement were classified as successful, whereas only 12 per cent of those employed fell into the unsuccessful category. Of those males who were not employed at any time during their placement, the figures were almost completely reversed, with 36 per cent falling into the unsuccessful category and only 12 per cent remaining in the successful category.

The wide differences between the two groups are placed into even bolder relief if it is noted that of the 21 males who were successful, 76 per cent were empljoyed at some time in placement. Of the 19 who were classified as unsuccessful, 79 per cent were not employed at any time during their placement.[9]

The absence of any significant differences between work and success for the female population can be explained by the fact that employment is not a normative expectation for this group. In view of the domestic role that is expected of the female population, the activities of the female clients was examined in greater detail. (Information was taken from the

TABLE 3.11

DISTRIBUTION OF ILP CLIENTS ACCORDING TO SEX, WORK AND SUCCESS IN PLACEMENT

Client Group	Work No.	Work p.c.	Non-Work No.	Non-Work p.c.	X^2	ro	P
Total group: (N=74)							
Successful	26	35	17	23			
Unsuccessful	9	12	22	30			
Total	35	47	39	53	7.14	.3	.02
Male group: (N=40)							
Successful	16	40	5	12			
Unsuccessful	5	12	14	36			
Total	21	52	19	48	9.90	.5	.01
Female group: (N=34)							
Successful	10	29	12	35			
Unsuccessful	4	12	8	24			
Total	14	41	20	59	NS	NS	NS

Typical Daily Report Schedule completed by most of the female clients.) Of the twelve successful females who were not working, two were married. Among the other ten, four had typical female avocational interests such as knitting and crocheting (which occupied a good part of their day), and two had hobbies that involved creative artistic work and designing.

A further indication of the positive effect of work is given by the results in Table 3.12, page 114. Of the clients who received a high score on their initial PFCS (indicating high psychopathology; see Appendix), three-fourths of the 60 per cent who worked were successful, while not one of the non-workers was successful.

The following two case studies illustrates the importance of work to the physically disabled male clients.

Case 1: Mr. X is a middle-aged client who for twenty years has been afflicted with primary spinal atrophy, a progressive disease involving gradual deterioration of the use of his legs. He now ambulates with a cane, cannot

TABLE 3.12

RELATION BETWEEN WORK, SUCCESS
AND HIGH PSYCHOPATHOLOGY
(N = 20)

Clients Ranking High on PFCS	Successful No.	Successful Per Cent	Unsuccessful No.	Unsuccessful Per Cent	Total
Work	9	45	3	15	12
Non-Work	0	0	8	40	8
Total	9	45	11	55	20

climb stairs, and falls frequently. His high intelligence and unusually strong drive had enabled him to take a few college courses and to work in export traffic for some twenty years. In recent years, however, his attempts to strive for independence by working have met with increasing frustration. He was dismissed from one job because of his hand tremors and was informed that he could not qualify for Civil Service. Finally, loss of his job with a state agency led to an attempt at suicide and confinement to a nursing home.

Case 2: Mr. Z is a 25 year old wheelchair-bound paraplegic man --his condition the result of a fall from a roof several years ago. Prior to his accident, he lived in furnished rooms in New York City, and worked sporadically at a series of marginal jobs. While in the hospital, he was found by the hospital staff to be defiant and hostile. However, when he was given a clerk errand job, his attitude changed and he became eager for foster home placement and financial independence.

Mr. Z was tested by DVR and was sent to the School of Visual Arts for an 18 month course in industrial drawing. In spite of his training, he could not find a job. During this period he was placed in, and subsequently left two foster homes, and moved instead to several hotels. His aggressiveness and hostility increased. He was committed briefly to a psychiatric ward.

In order to discover whether or not the age of the client was related to success (the premise being that the older the client the weaker his need for work), an analysis of the data was made. The initial expectation was that the male clients above the age of 40 (the age of "establishment") might not have as great a need to work as those below 40.

However, as indicated in Table 3.13, below, there is no significant difference that can be shown between the two age groups with regard to the relationship of work to success.

TABLE 3.13

DISTRIBUTION OF ILP MALE GROUP ACCORDING TO AGE, WORK AND SUCCESS IN PLACEMENT (N = 40)

Age	Successful		Unsuccessful	
	Work	Non-work	Work	Non-work
Under 40	11	3	3	8
41 - 60	5	2	2	6

Need Achievement and Success

To test the hypothesis more directly, an indicator of the level of the client's "need achievement" was used. The information was obtained from the adjective rating scale, a form filled out by the SWs for each client. From this form a number of adjectives related to need for achievement was compiled and the clients were then classified as either High Need Achievers (HNA) or Low Need Achievers (LNA). (See Table 3.14, page 116. See Appendix for the description of the scale and the system of classification that was used.)

The analysis of Table 3.15 (page 116) indicates that that was no significant difference between HNA and LNA groups and their success in the program. It was expected that some relationship between need achievement and sex would be found. Although the males were found in greater numbers in the HNA category, no significant difference was noted.

TABLE 3.14

DISTRIBUTION OF ILP CLIENTS ACCORDING TO CLASSIFICATION ON NEED ACHIEVEMENT SCALE AND SUCCESS IN PLACEMENT (N = 52)*

Degree of Success	HNA No.	HNA Per Cent	LNA No.	LNA Per Cent
Successful	17	33	14	27
Unsuccessful	14	27	7	14
Sex:				
Male	18	35	11	21
Female	13	25	10	19

*It was not possible to get these data on the complete sample.

X^2 - NS

TABLE 3.15

DISTRIBUTION OF ILP CLIENTS ACCORDING TO WORK, NEED ACHIEVEMENT AND SUCCESS (N = 52)*

Need Achievement	Successful				Unsuccessful			
	Work		Non-work		Work		Non-work	
	No.	p.c.	No.	p.c.	No.	p.c.	No.	p.c.
HNA	12	23	5	10	2	4	12	23
LNA	6	12	8	15	3	6	4	8
Total	18		13		5		16	

*It was not possible to get these data on the complete sample.

X^2 - 5.16; df - 3; NS

Various relationships among all the factors were investigated. The overall results indicate that there are no significant differences, except when there is control for HNA. We find that for the HNA group, there is a highly significant relationship between working and success, as is evident from Table 3.16 (below). This supports the major hypothesis which posited that those clients who had high need achievement and were able to attain their objective, as indicated by their having worked while in the community, would be significantly more successful than those who had their aspirations blocked and were unable to find employment.

TABLE 3.16

RELATION BETWEEN WORK AND SUCCESS IN PLACEMENT FOR HIGH NEED ACHIEVERS (N = 31)

Employment	Successful		Unsuccessful	
	No.	Per Cent	No.	Per Cent
Work	12	39	2	6
Non-work	5	16	12	39
Total	17		14	

X^2 - 9.82; ro - .56; P .01

Another more direct indicator was used as a basis for identifying the population with high achievement or attainment needs: the Edwards Personal Preference Test. Unfortunately, not all of the clients were able (or willing), to fill out the test, and a number of others who had left the program before the tests were given, could not be located.

The results for those clients who were included in the program are indicated in Table 3.17 (page 118). The most interesting trend is the one illustrated by the males with high need achievement (HNA group), which in effect supports the general hypothesis relating need achievement, work and success. Although the N is quite small, almost all of the HNA males who were working were successful, whereas the reverse was true for the HNA males who were not working. This pattern does not appear to hold for the females, and an explanation for this finding is discussed later in the chapter.

TABLE 3.17

SEX, NEED ACHIEVEMENT (EDWARDS), WORK AND SUCCESS IN PLACEMENT

Need Achievement	Successful		Unsuccessful	
	Work	Non-work	Work	Non-work
Male (N = 23)				
HNA	8	0	1	5
LNA	6	1	1	1
Female (N = 21)				
HNA	4	5	3	2
LNA	4	2	0	1

Deprivation, Need Achievement, Work and Success

As outlined earlier, clients were classified into a "Deprived" or "Non-Deprived" group according to their childhood and pre ILP experiences. The assumptions were that clients who were in the Deprived group would have lesser expectations regarding work because their past experience had conditioned them to expect less from life and they would thus not be as severely affected when they could not find work. The Figures of Table 3.18, below, indicate that this distinction holds true only for the Non-Deprived group, although there is a large difference between the two groups with respect to success when comparing the non-working population.

TABLE 3.18

DISTRIBUTION OF ILP CLIENTS ACCORDING TO WORK, DEPRIVATION AND SUCCESS IN PLACEMENT

Success	Work		Non-work		Total
	No.	Per Cent	No.	Per Cent	
Deprived: (N = 44)					
Successful	18	41	11	25	29
Unsuccessful	7	16	8	18	15
Total	25		19		
NS					
Non-deprived: (N = 30)					
Successful	8	27	6	20	14
Unsuccessful	2	7	14	46	16
Total	10		20		
ro = .47; p .02					

In an earlier analysis, it was found that mobility (wheelchair movement versus ambulation) played a significant role in the success of the clients. Analysis of the various interaction effects when introducing the factor of work indicates that the wheelchair clients are affected somewhat less than ambulatory clients in their successful adjustment when not working. Further breakdown (see Tables 3.19, 3.20 and 3.21), although limited somewhat by the small number of clients in each category, did not reveal any additional significant difference between the successful and unsuccessful groups.

TABLE 3.19

WORK AND DEGREE OF MOBILITY

Mobility	Work Per Cent	100 p.c. Equals	Non-work Per Cent	100 p.c. Equals	ro
Wheelchair bound	26	35	31	39	NS
Ambulatory (successful group)	65	26	34	27	.32*

*p .05

TABLE 3.20

MOBILITY, WORK AND SUCCESS IN PLACEMENT

Work	Per Cent Success	100 p.c. Equals	Per Cent Unsuccessful	100 p.c. Equals	or
Ambulatory:					
Work	65	26	100	9	.34*
Non-work	53	17	82	22	.31**
Ambulatory males:					
Work	80	17	34	15	.43***

*p .05; **p .06; ***p .025

TABLE 3.21

MOBILITY, SUCCESS AND AGE OF ONSET OF DISABILITY IN THE NON-WORKING GROUP

Mobility	Successful No.	Successful Per Cent	Unsuccessful No.	Unsuccessful Per Cent	Total
Age of onset over 10 years:					
Ambulatory	4	17	15*	63	19
Wheelchair	3	12	2	8	5
Total	7		17		24
Age of onset under 10 years:					
Ambulatory	5	33	3	20	8
Wheelchair	5	33	2	14	7
Total	10		5		15

*9 of this group were ambulatory males.

Education, Work, Sex and Success

Although there are large differences with regard to education and success of the non-working population, the relationship is reversed for each sex (see Table 3.22, page 121). Thus females who were high school graduates and who were not working were more successful than those with less than a high school education who were not working. The reverse, however, holds true for the males.

These differences with regard to level of education and success of the males in the program support the general hypothesis of the relationship between need achievement and success. The only conclusion that is suggested about the female population (in view of small numbers in each of the subcategories) is that they benefited from the lower societal expectations regarding work. For males with a high school education, the expectation of a job carries more weight, both for society and for the individual concerned. In addition, among high school graduates, the prospect of life without work is less of a problem for females than for males, as society does not expect them to fulfill a role as a worker or breadwinner. The female is expected to fulfill the role of the homemaker, in which there is a heavy emphasis placed upon physical coordination (such as sweeping and washing). The uneducated housewife

TABLE 3.22

EDUCATION, WORK, SEX AND SUCCESS
IN PLACEMENT
(N = 74)

Education Level	Successful		Unsuccessful	
	Work	Non-work	Work	Non-work
Males (N = 40)				
Less than H.S. Graduate	9	5	3	5
High School Graduate	7	0	2	9
Females (N = 34)				
Less than H.S. Graduate	6	1	0	9
High School Graduate	4	8	4	2

is more likely to enjoy the homemaker's role, whereas the educated housewife generally enjoys an opportunity to engage in activities with greater intellectual substance. Thus the physically handicapped female who is in the uneducated category is more likely to suffer from role interference and resulting boredom. The educated female, however, can still participate in more sedentary activities (for example, reading and conversation) and is thus probably less affected by her disability because of her greater repertoire of skills in dealing with enforced idleness.

VIII. CONCLUSIONS

The result of the search for differences in the factors that might be related to the success of the clients in the program indicate the following:

1. Male clients who have a high need achievement and were able to find work were more successful--(that is, they remained in the community without deteriorating physically or mentally) than HNA males who did not work.

2. For the female clients there is a similar relationship. However, keeping occupied with other

activities related to their social role was also related to success.

3. The clients who have been disabled since childhood and who are wheelchair-bound were not as affected by not being able to work, and were more successful although they had not worked.

The results are not unexpected, and although other intervening variables; namely, the foster home activities of the social worker played a role in determining the success of the client, it is reasonable to conclude that the need of some of the males to fulfill a meaningful social role (generally as a result of the previous experiences and their inability to do so) was an important factor in contributing to their eventual failure in the community.

A reasonable explanation for the results found in the study lie in the effects of a lifetime of deprivation on the expectations and ambitions of physically disabled adults. The disabled adults with a history of deprivation have probably established for themselves an equilibrium level that allows them to remain on an even emotional keel when they are confronted with vocational failure. These adults probably have as their reference group other severely disabled individuals and they have internalized the "low expectations" that society has of this group, particularly with respect to holding a job.

This explanation does not, of course, apply to the entire group, for there is evidence that a number of those disabled in childhood retained a high need for achievement. Adults who have become disabled later in life, after having fulfilled a role as a non-disabled adult (or at least identifying with the non-disabled in their view of society's expectations of their social role), find it hard to become reconciled to their new role, and become emotionally unstable when confronted with failure in their attempt to fulfill the occupational role.

This study indicates the need for further research along these lines. The implications are that it is easier to maintain a disabled adult who has a history of deprivation in the community than the one without a history of deprivation. The conclusions also indicate that perhaps a new approach is needed for clients (particularly males) who have a high need to achieve and to fulfill culturally prescribed occupational roles.

REFERENCES

[1]Henry J. Meyer, Edgar F. Borgatta and Wyatt C. Jones, Girls at Vocation High--An Experiment in Social Work Intervention (New York: Russell Sage Foundation, 1965), p. 207. The authors also note that: ". . . evaluative research is itself a potent strategy for promoting clarity of goals of treatment, conceptualizations of treatment modes, and theories of behavior that 'basic' research requires. The requisites of the sort of evaluative research reported here force attention to issues not otherwise readily recognized."

For systematic discussion of the problems of evaluative research on assessing psycho-social change in individuals, see E. Herzog, Some Guide Lines for Evaluative Research, U.S. Department of Health, Education, and Welfare, Social Security Administration - Children's Bureau, Publication No. 375 (Washington: Government Printing Office, 1959), p. 117.

Herbert H. Hyman, Charles R. Wright, and Terence K. Hopkins, Applications of Methods of Evaluation, Four studies of the encampment for citizenship (California: University of California Press, Berkeley and Los Angeles, California, 1962), pp. 1-86.

"This classic design has been a model available to all experimenters and evaluators for many decades. It has been prominently displayed and eloquently described, and it provides an automatic, packaged solution to the vexing problem of isolating all annoying extraneous sources of change. A paradox worth pondering is that, although the design has been attractively displayed for sale, very few evaluators have actually 'bought it,' and among those who have the product has usually been found deficient. The rejection of this design should not be interpreted as negligence. Often it means that the design cannot be translated into proper practice in evaluation studies because of conditions inherent in the operation of the programs. These conditions usually prevent obtaining an equivalent control group. The control groups that tend to be employed are poor simulations and the results consequently mislead rather than illuminate. At other times the practical priorities of the action program override the goals of evaluation and bar the evaluator's access to a good control group. In all such instances, slavish insistence on control group designs is unwise. The purist attitude may defeat any attempt to evaluate planned programs, or it may create false confidence in the results of poorly designed evaluations which only simulate equivalent control group, while undue skepticism is attached to the results of well-designed evaluations which

employ reasonable and sound alternatives to the classic design. Sometimes, too, it leads to a misdirection of energies; instead of devoting exclusive attention to obtaining a control group that is likely to be inadequate, the evaluator could develop a variety of inferential and indirect devices for enhancing his ability to impute casual significance to the program."

For a somewhat different point of view on evaluative research and its problems, see: Melvin Herman and Stanley Sadofsky, Youth-Work Programs - Problems of Planning and Operation (New York: Center for the Study of Unemployed Youth, Graduate School of Social Work, New York University, 1966), Chapter II.

[2]Denise Brystryn Kandel and Richard Hays Williams, Psychiatric Rehabilitation (New York: Atherton Press, 1964), pp. 132-33. The authors note a comment by the Group for the Advancement of Psychiatry:

"There are studies in which two groups ('experimental and control') are matched on one or a few variables of minor significance (for the particular problem under study) while variables of major significance to the inquiry (on the basis of clinical experience) are left totally out of consideration --because they are not recognized or because they are thought to have an unwanted complexity. Such studies illustrate a kind of pseudo-control. At best they are a step in the direction of more rigorous research; at worst, they are misleading because they appear to do much more than they actually accomplish. This kind of rigor can become rigor mortis for research, in the sense that the investigator may be willing to sacrifice the heart of his problem in order to achieve a facade of scientific respectability."

Also see Henry J. Meyer and Edgar F. Borgatta, An Experiment in Mental Patient Rehabilitation--Evaluating a Social Agency Problem (New York: Russell Sage Foundation, 1959), p. 102. Although the researchers had been able to set up a control group, they ran into two problems that may be inevitable in certain situations when control groups are used: (1) limited supply of suitable subjects for the experiment, and (2) failure to bring all experimental subjects under treatment.

[3]The concept of "psychological disorganization" as viewed as a continuum has been utilized by many theoreticians and researchers. In this study extreme "withdrawal" or "aggression" was viewed as one extreme and measured by a total score in a number of factors (see PFCS) that were related to these broader behavioral concepts. See for example, Karl Menninger (and others), Vital Balance--The Life Process in

Mental Health and Illness (New York: The Viking Press, 1963).

Also, Thomas S. Langner and Stanley T. Michael, Life Stress and Mental Health--The Midtown Manhattan Study (London: The Free Press of Glencoe, Collier-Macmillan Limited, 1963), pp. 87-88.

Although there have been many viewpoints expressed regarding the relationship of specific disease entities and the personality of disabled individuals, the assumption in this study was that many of the disabled individuals in these categories exhibit personality stability, that is, having a certain type of disability does not automatically result in severe personality disorganization. See in particular James F. Garret and Edna S. Levine, Psychological Practices with the Physically Disabled (New York: Columbia University Press, 1962).

[4]Howard R. Kelman, "Evaluation of Rehabilitation for the Long Term Ill and Disabled Patient: Some Persistent Research Problems," Journal of Chronic Diseases, Vol. 17 (1964), pp. 631-639.

H.R. Kelman and A. Willner, "Problems in Measurement and Evaluation of Rehabilitation," Arch. Phys. Med., Vol. 43 (1962), p. 172.

[5]The factors included in the scale were partially suggested by the study on the employability of the Cerebral Palsied. The authors noted that the: ". . . employable group had better speech, gait, and ability to travel in spite of similar motor involvement." See Martin Moed and Dorothy Litwin, "The Employability of the Cerebral Palsied--A Summary of Two Related Studies," Rehabilitation Literature (September 1963), p. 266.

[6]A similar conclusion was noted by others: "We found that success in rehabilitation had absolutely no correlation with the severity of the neurological lesion. You could have an individual that remained completely paralyzed on his side and aphasic that made a good adjustment, could go home, could meet the needs of daily living, apparently relatively well adjusted. You get another man who had nothing but a little residual in his hand and you couldn't do anything with him." See Howard A. Rusk, "Next Steps in Rehabilitation," Psychology and Rehabilitation, ed. Beatrice A. Wright (Washington, D.C.: American Psychological Association, 1959), pp. 104-105.

[7]Lloyd H. Lofquist, "Psychological Research and Rehabilitation" (Miami Beach, Florida: Conference by American Psychological Association, November 9-12, 1960), p. 143. See Chapter V on "Personality, Motivation and Clinical Phenomena" for a detailed outline of this theory.

[8]O.G. Simmons and U.E. Freeman, The Mental Patient Comes Home (Illinois: Free Press of Illinois, 1962).

[9]In another study, the researchers found results that place our study in further prospective from a report by M. Clark and I. Rossman, M.D., Jobs for the Homebound Project (New York: Division of Social Medicine, Department of Home Care, Montefiore Hospital, March 1, 1956).

a. Early age at onset of illness was associated with good response to work. Eight of the patients admitted to JHP were relatively young people, aged 16 to 41, who had been ill since birth or early childhood. All except one accepted work with enthusiasm, and the patient who rejected work was satisfactorily occupied with an interest in creative writing.

b. Further evidence of the association between response to work and early age at onset of illness was seen with four unmarried women in their 50's and 60's who had been ill since childhood or early adulthood. With the exception of one patient who was mentally defective, these women were prolific, enthusiastic workers. All of these women were quite immature. For them, a major satisfaction in work was that it provided a simple, guided type of activity.

c. Men experienced marked improvement with work far more often than women. There was 57.8 per cent of the men and 19 per cent of the women that showed marked improvement with work. In all other areas sex differences were negligible.

It had been anticipated that the work program would be more applicable to men than women and that work would be of interest primarily to women for whom a job had been a primary source of satisfaction prior to illness. Project experience did not bear out this assumption. Although all of the women admitted to JHP who had rewarding work experiences prior to illness accepted work, their interest was not necessarily intense. Furthermore, many of the most prolific workers were women who had little or no work experience prior to illness.

For an interesting brief analysis of need for work also see Celia Benney, "Factors Affecting Motivation for Rehabilitation," Psychiatric Quarterly Supplement, Vol. 38, Part 2 (1964), pp. 205-220.

CHAPTER IV

FOSTER FAMILY: EFFECTS AND ANALYSIS

As this project could not have been undertaken without the cooperation of many families in the community who offered their homes to the clients, it is important to study some of the characteristics of these families in relation to the adjustment of the clients.

I. THE ROLE OF THE FOSTER FAMILY IN THE CLIENT'S ADJUSTMENT

The role of the foster family, in its effects on the client's adjustment in the community, was difficult to assess because the variety of family types was extremely large (see section on Socio-demographic Characteristics of Foster Families, Chapter I.

In addition to this major factor, there was also a distinction in the type of neighborhood in which the family was located, namely, suburban or non-suburban. An analysis of the data indicates that there was no significant relationship between the client's location and his success in placement (see Table 4.1, page 128).

In view of the significant relationship found between working and success and the possible differential effects of location on males and females, further analysis of the data was undertaken, with no significant results.

TABLE 4.1

THE RELATION BETWEEN FOSTER HOME LOCATION
AND SUCCESS IN PLACEMENT
(N = 74)

Location	Successful		Unsuccessful		Total
	No.	Per Cent	No.	Per Cent	No.
Suburban Foster Home	15	20	10	14	25
Urban Foster Home	28	38	21	28	49
Total	43		31		74

II. MOBILITY AND SUCCESS

It was anticipated that there might be a relationship between mobility, location, and success. According to this line of reasoning, wheelchair-bound clients living in suburban foster homes would find difficulty in reaching their place of work, friends, relatives, and recreational activities, and this isolation would militate against successful adjustment. However, in analyzing the results and controlling for the factor of work, no significant difference between wheelchair clients in urban and non-suburban settings was found.

III. FOSTER HOMES--FOSTER FAMILY INCOME AND SUCCESS

Interviews with the clients revealed that their major complaints focused on monetary matters. In particular, they

felt that the areas of food and use of telephone were major sources of friction between themselves and the foster family. It was therefore hypothesized that families whose income was below approximately $4,000 would make adjustment most difficult, thereby resulting in the client's unsuccessful adaptation to community life. However, no significant difference among the families of different income levels was found with regard to the clients' success in the community. Further breakdowns of foster family income level also failed to reveal any significant differences (see Table 4.2, below).

TABLE 4.2

FOSTER FAMILY INCOME AND SUCCESS OF PLACEMENT
(N = 74)

Foster Family Income	Placements: Successful No.	Successful Per Cent	Unsuccessful No.	Unsuccessful Per Cent	Total No.
Over $4,000	25	34	16	22	41
Under $4,000	18	24	15	20	33
Total	43		31		74

IV. FOSTER FAMILY COMPOSITION

The composition of the foster family was another variable that was expected to affect this adjustment of the client. The presence of a male adult in the family provides a different structure for client-family interaction (see Table 4.3, page 130).

TABLE 4.3

WORK, SEX OF CLIENT, MALE IN FOSTER FAMILY AND SUCCESS OF PLACEMENT (N = 74)

Foster Family	Client Working: Successful No.	Client Working: Successful p.c.	Client Working: Unsuccessful No.	Client Working: Unsuccessful p.c.	Client Not Working: Successful No.	Client Not Working: Successful p.c.	Client Not Working: Unsuccessful No.	Client Not Working: Unsuccessful p.c.
Male Clients:								
Male in F. Home	11	52	3	14	2	11	10	53
No Male in F. Home	5	24	2	10	3	16	4	20
Total	16		5		5		14	
Female Clients:								
Male in F. Home	7	50	2	14	8	42	5	26
No Male in F. Home	3	22	2	14	4	21	3	15
Total	10		4		12		8	

Although there was no overall significant difference, when controlling for work and for sex of the client, there was, however, a significant relationship among those not working and the sex of the client, when a male was present in the foster home household (see Table 4.4, below).

TABLE 4.4

DISTRIBUTION OF NON-WORKING CLIENTS ACCORDING TO MALE IN FOSTER FAMILY AND SUCCESS IN PLACEMENT (N-25 = 100 Per Cent)

Non-working Clients	Successful No.	Successful Per Cent	Unsuccessful No.	Unsuccessful Per Cent	Total No.
Males	2	8	10	40	12
Females	8	32	5	20	13
Total	10		15		25

$x^2 = 5.23$; p .05; ro .45.

It is probable that, for the non-working male client, the presence of a male adult in the family may by contrast have given the client an unfavorable self-image. This conclusion is tenable in view of the fact that in 92 per cent of the cases, the male member of the household (where there is a non-working male client) is working, frequently in a professional or skilled position.

Although there were not many families with young children in the household, it is possible, on the basis of some of the case reports by the social workers, to discern an advantage in their presence for the disabled client. The following is an illustration, described by the social worker, of a successful, unemployed, female client who was kept occupied in the foster home because of the presence of children:

> Mrs. Jones became friendly with Mrs. Brown at the hospital where Mrs. Jones was a patient and Mrs. Brown an attendant. Although the home was small and very untidy, Mrs. Jones preferred to try it since she felt so comfortable with Mrs. Brown. There are five children in the home. Mrs. Brown thinks of Mrs. Jones as "a substitute mother," since she hasn't a mother of her own. Mrs. Jones is "no trouble at all." The baby hugs and kisses her and the children call her another "mommy." Mrs. Jones finds that there is "so much company around" and she and the children watch T.V. together. She loves the children and does not find them too noisy, and the two older boys get books for her from the library. She plays cards and checkers with the boys and enjoys it very much. She also keeps busy making a quilt and sewing.

An unexpected large number of foster mothers indicated that they had had previous experience with the handicapped. As categorized in Table 4.5 (page 132), however, no significant trends were noticeable with regard to the relationship between

TABLE 4.5

RELATION OF FOSTER MOTHER'S EXPERIENCE WITH DISABLED PEOPLE AND SUCCESS OF PLACEMENT (N = 74)

Experience of Foster Mother	Client: Successful Work M	Successful Work F	Successful Non-Work M	Successful Non-Work F	Unsuccessful Work M	Unsuccessful Work F	Unsuccessful Non-Work M	Unsuccessful Non-Work F
Professional and/or boarder/self	6	4	4	5	1	1	5	2
Immediate family and other	3	1	1	0	0	0	1	0
Immediate family and no other	1	2	0	4	2	0	1	5
Other	4	1	0	4	2	1	3	1
None	2	1	0	0	0	2	4	0

nature of the experience and the clients' success, when controlling for sex and work status. The experience categories were collapsed into two groups for further analysis. There appears to be some advantage in seeking a foster mother who has had experience in working with the disabled when looking for a home for the unemployed male client (see Table 4.6, page 133).

It appears from Table 4.7 (page 133) that non-working male clients in the Group I foster homes were more successful than those in Group II homes. The experience of the Group I foster mothers was apparently an important factor in the community adjustment of the non-working male client.

TABLE 4.6

RELATION OF FOSTER MOTHER'S EXPERIENCE WITH DISABLED PEOPLE AND SUCCESS OF PLACEMENT
(N = 74)

Experience of Foster Mother	Client: Successful Work M	Successful Work F	Successful Non-work M	Successful Non-work F	Unsuccessful Work M	Unsuccessful Work F	Unsuccessful Non-work M	Unsuccessful Non-work F
Group I: Professional and/or Boarder	9	5	5	5	1	1	6	2
Group II: Immediate Family and No Other; Other; None	7	4	0	8	4	3	8	6

TABLE 4.7

RELATION OF FOSTER MOTHER'S EXPERIENCE WITH DISABLED PEOPLE AND SUCCESS OF PLACEMENT OF NON-WORKING MALE CLIENTS
(N = 19)

Experience of Foster Mother	Client: Successful No.	Successful Per Cent	Unsuccessful No.	Unsuccessful Per Cent	Total No.
Group I: Professional and/or Boarder and/or Self, or Immediate Family	5	26	6	32	11
Group II: Immediate Family and No Other; Other; None	0	0	8	42	8
Total	5		14		19

V. STYLE OF LIFE: FOSTER FAMILY AND CLIENT'S SUCCESS

In placing clients, the social workers found that the socio-economic class was an important determinant in the client's choice of a foster home. Clients who had been accustomed to a "style of life" that was associated with a higher socio-economic class sometimes rejected a home on appearance alone. For example, a Negro home was rejected by many because of the stereotype that the home was lower class even though many of the Negro families who applied were middle class.

Although the SWs were not in a position to match the client's style of life (see Appendix for items in Style of Life Schedule) to an appropriate foster family in making a placement, it was assumed that complementary interests and views might be related to the success of the client. The preferences of the client and of his foster family were compared on the 12 items of the Style of Life Schedule which logically permitted such comparisons. Agreement with foster family on 60 per cent or more of the items placed the client in the high agreement category (HA). Agreement on less than 40 per cent of the items placed the client in the low agreement category (LA). These two extreme groups were compared in our analysis (see Table 4.8, page 135), while the middle range group, agreeing on between 40 and 60 per cent of the items, was omitted.

Analysis of the data in Table 4.9 (page 135) indicates that high agreement on Style of Life plays some role in success

TABLE 4.8

CLIENT AND FOSTER FAMILY AGREEMENT ON STYLE OF LIFE, WORK, AND SUCCESS OF PLACEMENT (N = 45)

Style of Life	Clients: Successful (31) Work No.	p.c.	Non-work No.	p.c.	Total	Unsuccessful (14) Work No.	p.c.	Non-work No.	p.c.	Total
High agreement	16	52	6	19	22	3	22	6	44	9
Low agreement	4	13	5	16	9	0	0	5	34	5
Total	20		11		31	3		11		14

TABLE 4.9

HIGH AGREEMENT ON STYLE OF LIFE OF FOSTER FAMILY AND NON-WORKING CLIENTS (N-12 = 100 per cent)

Client	Client Placements: Successful No.	Per Cent	Unsuccessful No.	Per Cent	Total
Male	0	0	4	33	4
Female	6	50	2	17	8
Total	6		6		12

only for the non-working female population. In view of the amount of time that the non-working female client would spend in the home with the foster mother, the sharing of similar activities and interests (reading the same newspapers and watching the same TV programs), would provide for a congenial and mutually satisfactory relationship.

Other foster mother characteristics in relation to the

degree of success of the placements are shown in Table 4.10.

TABLE 4.10

RELATION OF CHARACTERISTICS OF FOSTER MOTHERS TO SUCCESS OF PLACEMENTS (N = 74)

Characteristics	Clients: Successful M.	Clients: Successful F.	Clients: Unsuccessful M.	Clients: Unsuccessful F.
Clients' Age:				
Under 35 years	14	13	9	5
35 - 50 years	4	4	8	6
Over 50 years	3	5	2	1
Total	21	22	19	12
Foster Mothers' Age:				
Under 35 years		5		1
35 - 50 years		23		14
Over 50 years		15		16
Total		43		31
Foster Mothers' Age:				
Under 35 (6) and				
Client's age: Under 35		3		1
35 - 50 years		0		0
Over 50 years		2		0
35 - 50 (37) and				
Client's age: Under 35		14		9
35 - 50 years		7		4
Over 50 years		2		1
Over 50 (31) and				
Client's age: Under 35		10		4
35 - 50 years		1		10
Over 50 years		4		2
Total		43		31
Foster Mothers' Educational Level:				
High School or above		22		20
Some H.S. or below		21		11
Foster Family Income:				
Over $4,000		25		16
Under $4,000		18		15

CHAPTER V

IDENTIFICATION OF FACTORS RELATED TO CLIENTS' PROGRESS IN THE COMMUNITY

In the previous chapters, an analysis of the components related to the client's failure was performed. Each major factor that may have played a role in the client's success in the community (social work intervention, foster family) was also brought into the analysis to determine the possible features of those components that may have been related to the client's adaptation in the community. Although we were unable to ascertain the weight of the variables involved because of the complexity and type of data (which did not permit the use of certain statistical techniques), the material was introduced to shed some further light on the whole process of the ILP.

The general analysis did not include the incorporation of a number of other variables that were available, namely, the client's subjective view of his health, the level of his interpersonal relations in the community. In this chapter these factors are further analyzed.

Client's Subjective View of His Health and Success

A comparison of the scores on the Interval Health History (the client's periodic report on his view of the state of his health) for the successful and unsuccessful clients and the work versus non-work groups showed no significant differences among the groups (see Table 5.1, page 138). However, in performing this analysis for the non-working, a significant difference

TABLE 5.1

SUMMARY OF "T" TESTS (DIFFERENCE OF MEANS ON INTERVAL HEALTH HISTORY ITEMS 1-7*

Factors	N	Mean	T	P
Success	(40)	10.60	1.84	.07
vs.				
Unsuccessful	(24)	12.17		
Work	(31)	10.97	.99	NS
vs.				
Non-work	(33)	11.70		
Non-working Group Only				
Success	(15)	10.27	2.82	.02
vs.				
Failure	(18)	12.89		

*See Appendix for Interval Health History questionnaire and scoring system.

was found between the successful and unsuccessful groups. This result indicates that the clients who were not working and who were classified as unsuccessful complained more frequently about their health and saw themselves in a "poorer" state of health than the successful non-working clients. Although there is no information illustrating any direct relationships, it would appear that clients who were not working showed a tendency towards hypochondriasis, inasmuch as no direct relation was found between the objective indicators of the client's health and his own view of the state of his health.

Baseline scores on the Interval Health History for many clients were not available. It was not, therefore, possible to determine the relationship, if any, between the client's initial tendency towards viewing his state of health as "poor" and his views at a later date. However, there was an initial evaluation of the client's general state of health at the time of placement, recorded by the SW, based on interviews with the client. A comparison of this evaluation with the client's score on the Interval Health History at a later stage indicated there was no significant correlation between the two ($r = .06$).

The Interval Health History forms were completed by clients at various intervals in the program. The scores that

are included here are taken from that period closest to the client's time of failure, and at the six-months-to-one-year period for successful clients. A few of the scores were taken from the client's schedule at the two-year period.

There does not appear to be any relationship between the client's high score on the Interval Health History and on the client's need for hospitalization and medical care during his stay in the community, thus indicating that the client's complaints were probably psychosomatic in nature, revealing his general state of depression.

Interpersonal Relations (IR)

One of the major needs of our clients, as with all human beings was the need for human companionship. The IR questionnaire was an attempt to assess the quality and quantity of the client's interpersonal relations. (See Appendix for IR Questionnaire; Note: a low score indicates a high level of interpersonal relations.)

The relation between success and high IR approaches but does not quite reach the .05 level of significance (see Table 5.2, below); a strong trend is indicated.

TABLE 5.2

SUCCESS AND INTERPERSONAL RELATIONS

Clients' Status	N	Mean	S.D.	T	P
Successful	40	1.43	.54	1.94	.06
Unsuccessful	25	1.68	.44		

An analysis of the relationship between success and interpersonal relations for our non-working population (see Table 5.3, page 140), shows a significant difference between the two groups. (Note: High level IR is indicated by a low score on the IR Inventory; see Appendix.)

In further breakdowns, it was found that there was a significant difference only for the female, non-working group, and not for their male counterparts. This result is not surprising, since a high level of IR for our female clients is probably a more adequate substitute for work than it is for the male clients (see Tables 5.4 and 5.5, page 140).

TABLE 5.3

SUCCESS AND INTERPERSONAL RELATIONS:
NON-WORKING POPULATION

Clients' Status	N	Mean	S.D.	T	P
Successful	17	1.4	.98	2.06	.05
Unsuccessful	19	1.7	.46		

TABLE 5.4

SUCCESS AND INTERPERSONAL RELATIONS:
NON-WORKING MALES

Clients' Status	N	Mean	S.D.	T	P
Successful	5	1.4	.31	.8	NS
Unsuccessful	12	1.6	.40		

TABLE 5.5

SUCCESS AND INTERPERSONAL RELATIONS:
NON-WORKING FEMALES

Clients' Status	N	Mean	S.D.	T	P
Successful	11	1.4	.31	2.54	.05
Unsuccessful	7	1.9	.47		

Additional Correlates of Clients' Adjustment

The clients and foster families in the ILP were given a series of personality tests, including the Taylor Manifest Anxiety Scale, "F" Scale (controlled for response-set bias),

Hostility-Guilt Inventory, MMPI, Edwards Personal Preference Schedule, and the Life Satisfaction Index (LSI).

Unfortunately, a number of the clients did not complete the tests with the consistency and reliability required, and their tests could not be used in any analysis.

A comparison of the test scores that were available (the number was small) for the successful and unsuccessful clients and their foster families did not reveal any significant differences, nor did an examination of the results for various sub-groups.

The lack of significant differences in these results can be easily explained by the diversity of personality types in this program and problems that are unique to the utilization of objective personality tests with the disabled.

(A detailed analysis of the test results was not undertaken because of the factors mentioned above, the nature of the results found earlier, and insufficient time. It is expected that some of the data collected will be reported in a later monograph.)

CHAPTER VI

ANALYSIS OF ENVIRONMENTAL CHANGES OF SUCCESSFUL CLIENTS

The reasons for environmental changes made by the unsuccessful clients have been treated extensively in several chapters of this report. But change is not the exclusive province of the unsuccessful; 42 per cent of the 45 changers in our population were successful clients. What were their reasons for making these changes? In terms of concrete and explicit reasons, apparent to client, foster family and SW, a variety of complaints and conflicts have already been catalogued. However, there is a need to search elsewhere for full understanding of the causes which underlie the stated reasons; the answers, when forthcoming at all, are not usually as simple or apparent as might be hoped for.

An analysis of the population, broken down according to success, work and sex revealed the distribution shown in Table 6.1 (page 143).

An analysis of the successful group (see Table 6.2, page 143) reveal that the female clients who are working make more changes than the non-working female group. This does not appear to hold true for the corresponding male population.

We do not have sufficient evidence to explain why female workers tend to show a higher percentage of change, while female non-workers tend to remain in the same Foster Home.

TABLE 6.1

DISTRIBUTION OF CLIENTS ACCORDING TO SUCCESS, WORK, SEX AND ENVIRONMENTAL CHANGE (N = 74)

Clients	Successful (N-43 = 100%)				Unsuccessful (N-31 = 100%)			
	Work		No Work		Work		No Work	
	M	F	M	F	M	F	M	F
Change in F.H.	14	16	2	7	16	10	39	23
No Change in F.H.	23	7	9	21	0	3	6	3

TABLE 6.2

WORK AND CHANGE OF FOSTER HOME FOR SUCCESSFUL CLIENTS

Clients	Working		Not Working		Total
	No.	p.c.	No.	p.c.	
Females (N-22=100 p.c.)					
Change in F. Home	7	31	3	14	10
No change in F. Home	3	14	9	41	12
Total	10		12		22
	(X^2 = 4.45; p .05)				
Males (N-21=100 p.c.)					
Change in F. Home	6	29	1	5	7
No change in F. Home	10	47	4	19	14
Total	16		5		21

Additional Factors

Investigation of the relationship between environmental changes and the factor of origin (hospital versus unsuitable community environment) showed no significant connection. No connection was found between environmental changes and age, or mobility (wheelchair versus-non-wheelchair) for successful clients.

The successful CPs apparently made more moves from foster homes than other successful clients (see Table 6.3, below). Apparently, despite the success of these clients in remaining placed, there is a greater turnover in placements. Several reasons may account for this. Foster families may partake in the general prejudice against CPs. (One CP client mentioned how frequently she is mistaken for a drunkard because of her gait; a foster mother described how uneasy the athetoid movements of our client made her feel.) The difficulty in communicating with a client whose speech was affected by CP was an impediment to interpersonal relations in some foster homes. The awkward physical appearance of most CP clients and the problems involved in communicating apparently led to greater strain and thus greater movement for this group.

TABLE 6.3

SUCCESSFUL CEREBRAL PALSIED CLIENTS
AND ENVIRONMENTAL CHANGE
(N = 43)

Successful Clients	C.P. No.	C.P. p.c.	Non C.P. No.	Non C.P. p.c.	Total
Change	10	23	8	18	18
No Change	8	18	17	40	25
Total	18		25		43

CHAPTER VII

THE ROLE OF THE SOCIAL WORKER

Before presenting the research report on the effects of social work intervention, some of the service aspects of the project will be discussed.

As was mentioned in the Preface, all of the nine full time and part-time Social Workers in the project until the last year were graduates of a school of social work although only three SWs had had specific medical or rehabilitation orientation. It was a difficult but not an impossible transition for the others from specifically psychiatric social work to what might be termed physical and all encompassing social work. It was felt, however, that the more the "total" client was taken into consideration, the more truly the psychiatric aspects of the particular situation became paramount. The minor details became: building ramps, widening doors, lowering cupboards, arranging for transportation and interpreting the client's needs to other agencies. A major task was how to help a client to accept himself for the rest of his life in a wheelchair and to meet all of his community problems from a sitting position. All theoretical orientations for social work were pressed into service here.

The staff created an unusually accepting atmosphere for the clients. This was accomplished through planned supervisory orientation periods and through stress on democratic

behavior amongst staff members themselves. Many of the clients received medical care in hospitals where the clinics were large enough to deal with one diagnosis at a time. There were too many patients for individual attention to any but specifically medical questions. The office of the Independent Living Project (ILP) was small, the clients knew and often chatted spontaneously with Social Workers other than their own, and the friendliness of the small clerical staff sometimes made waiting more attractive than "being seen" by the SWs. Often the clients have said that the office was a "nice place" and that seldom anywhere else had they ever had a friendly arm across their shoulders. This point is emphasized in order to show the extreme former isolation and rejection of this population, the need for the reassuring physical contact, and the importance of a positive general atmosphere when attempting to serve them.

It was frustrating to the staff to realize that much of the progress of some of the clients was not measurable, or was not in evidence until after the closing date for data collection when several clients burst into unpredicted signs of independence. Also, the clients themselves could often not judge their own advance and only the SW was left with "knowing" that they were "catching on," less despondent, more active in interviews. This points up the necessity for the provision for a follow-up evaluation at some point after the termination of a project involving study of behavior. Apart

from the obvious environmental changes that can be shown, the social work process has never been judged on the speed of results. Unfortunately, then, any general cut-off date will eliminate some valuable data because of the wide range of time needed for human response to deliberate intervention.

The SWs, the entire staff, were "involved" which is not surprising when it is noted that they were helping the clients to plan every aspect of their lives through a twenty-four hour day. "How do I get breakfast?"--asked one young man who had had over twenty years of bedside trays without his request. "How do you dial a telephone number?"--asked another client who now had someone to call. "How much should a warm coat cost?" "Could I have a clock in my bedroom?" "Can I have a key to a door?" So the SWs became involved with the one thousand details and the growing hope for self-esteem behind the simple requests.

I. EFFECTS OF SOCIAL WORK INTERVENTION

The ILP was unique both in the demands made upon the social worker and in the opportunity it provided to combine a high degree of environmental manipulation, with direct counseling and intervention with others on behalf of the client. The role of the social worker in the ILP is similar to the role now being suggested as a prototype of the social worker needed in the future, namely, one which will combine environmental manipulation, providing direct services to the clients, and expediting community services for the clients.[1] (See

Charts I to III.)

Unfortunately the project was not established with this objective in mind of evaluating the effectiveness of the social work intervention. It was difficult, therefore, to determine the effectiveness of this multi-faceted role on the client's adaptation to community life.

An attempt was made to answer a number of questions albeit in a limited way. The answers below provide some perspective with which to view the nature of the problem areas and the types of assistance needed.

1. The type of social work services provided to the client were unusual in their intensity and scope. Although there was no control group to enable an evaluation of no service compared with intensive service (this would have been difficult to set up, as suggested earlier), it was possible to obtain information on one group that received only limited services. A comparison of these two groups was made, utilizing the limited information available.

2. Although it was not possible to specify the types of services needed to keep the clients in the community and to assist their progress in social and occupational functioning, the types of services provided and problems related to this area were examined in detail. An analysis of the systems functioning in this operation provides a clear picture of the areas of conflict, and the need for coordination and integration of services given. A further search was made for any direct relationships between the intensity of services, the types of counseling given the clients, and their success in the program.

3. Finally, it became evident that the social workers were a varied group. Although there were major factors that affected the client's success (apart from the services provided by the SW), an attempt was made to determine if the individual SWs differed in their ability to keep the client in the community. Having found what appeared to be varying degrees of success for the SWs, a brief analysis of the differences was performed, suggesting

the need for further exploration of the types of personnel who are more successful in working with a disabled population.

II. COMPARISON GROUP

One group that provided a measure of comparison with the work of our SWs was the population that had been placed by the Department of Welfare (DW) in foster homes after the ILP program had been underway for some time. Although all of the information for the DW group that was available for our population was not obtainable (the DW program was not a research program), it was possible to obtain some information from cooperating personnel who gathered for us whatever data was available. The assumption was that the services provided by the DW to the foster home family and clients were not on the same intensive or professional level as those provided by the ILP SWs, since the ILP was employing SWs on a larger scale with a larger budget, and they worked with far fewer cases than DW personnel generally handled.

The results initially showd that the ILP group of clients did not perform significantly better than the DW population when the criteria of success as defined in this program are used as bases for comparison (see Table 7.1, page 150).

In a further breakdown of the character of the population, it was apparent that the Department of Welfare population consisted of an older Negro group and that using a comparable group of clients could perhaps provide a better indication of the influence of the SW. In this analysis, no significant

TABLE 7.1

SOCIO-DEMOGRAPHIC COMPARISON BETWEEN
ILP AND DW CLIENTS
TOTAL ILP = 74, DW = 38

Factor	ILP	DW
Race:		
Negro	10	23
White	58	14
Puerto Rican	6	1
Successful:		
Negro	4	16
White	24	9
Age:		
Under 25 years	21	3
26 - 35 "	20	6
36 - 40 "	5	4
41 - 50 "	17	25
51 - 60 "	11	0
Successful	43	26
Unsuccessful	31	12
Age 40 and under:		
Successful	27	8
Unsuccessful	19	5
Total	46	13
Age 41 - 60:		
Successful	16	18
Unsuccessful	12	7
Total	28	25
Negroes Age 41 - 60:		
Successful	4	12
Unsuccessful	0	4

differences were found although there is a larger percentage of success for the DW. Additional analysis, however, indicates that the DW group that is most successful is the one composed of older Negroes and this accounts partially for the higher ratio of DW success. The older groups have a generally similar distribution of types of disabilities.

The greater success of the older Negro population provides some additional confirmation regarding the expectations of the disabled and the consequences of frustrated expectations. The older Negro population, it can be assumed, had lesser expectations about movement or advancement in the vocational or interpersonal areas, and as was indicated, the vast majority of this population suffered no adverse effects from not working while in the community. The conclusions would be that with this population, the intensive work done by the ILP SWs does not bring about measurably greater results when the variables of remaining in the community, or in a favorable foster home setting are considered. Of course, this is a minimal level of existence, and, by way of contrast, in the area of work advancement, it is clear that the ILP population made greater strides as can be seen in Table 7.2, page 152.

An interesting statistic developed with reference to the Negro population is illustrated in Table 7.3, page 152.

The ILP did not receive many Negro referrals and so was not able to place many Negroes. Some of the conditions

TABLE 7.2

EMPLOYMENT OF ILP AND DW CLIENTS
AFTER PLACEMENT

Client Group	No. Employed	Per Cent
DW (N = 38)	4	10
ILP (N = 74)	34	46

TABLE 7.3

COMPARISON BY RACE OF ILP AND DW CLIENTS
ACCORDING TO PLACEMENT AND REFERRAL

Client Group	ILP Placements	DW Placements	KLP Unplaced Referrals
White	58	14	83
Negro	10	23	14
Puerto Rican	6	1	4
Total	74	38	101

that may explain this factor have been noted earlier in the report. Yet it is interesting that the DW did place almost as many Negroes as the total number of referrals to the NYSOH, although admittedly it was mainly an older population. It is possible that many were not referred because the client did not want to be involved with a private agency. The whole

system of referrals, however, bears some further study with regard to its effects on other agencies and the services available.

Contrast Population

One other group was available as a contrast population. This group was composed of the approximately 250 referrals to the program of whom only approximately 80 finally became clients and were placed in foster homes (statistical information was available for only about 109 of the ILP group of referrals). An analysis of the questionnaires returned by this population (approximately 35 per cent of the total population) indicated that they were making a satisfactory adjustment on their own or with some minor assistance of another agency but that many were interested in receiving assistance in finding employment and a better place to live. Approximately 20 per cent were at the address given but did not respond. This non-response group had not moved to an institution and hence we assume had not deteriorated severely either mentally or physically. There was no way of determining if the residence of this group was of the type we had classified as a "negative environment." However, on the basis of the requests for better living accommodations by the group that did respond, it could be surmised that a large number were living in poor housing accommodations. The other 45 per cent had moved since the time the agency had been in touch with them; it could not be determined, however, if they had returned to an institution.

The only conclusions that could be made on the basis of the information collected about this group was that although they were able to make some adjustment in the community on their own, they differed from the ILP group in that they had been able or had decided to make their own arrangements and found some aspects of the program objectionable, or some alternative more attractive. Furthermore, based on the knowledge that was gathered from ILP group's adjustment to the community, it could be anticipated that a large number in this group would deteriorate. However, because of the neighborhoods in which the contrast groups lived and the tolerance for personality disorganization in these areas, their need for institutionalization would go unrecognized for a long period of time. The degree to which they would have achieved more had they been in the ILP program can only be surmised from the post-placement progress shown by the clients in the ILP.

III. SOCIAL WORK CONTACTS AND PROCEDURES

The social workers in the ILP played many roles, one of which was to intervene on behalf of the clients with many agency personnel (see Charts I to III). It was obviously not meaningful to evaluate the various interrelationships in view of the complexity of the systems within which the client and social worker were operating. However, it was possible to analyze the relationship between the success of the client and the intensity of the various intervention procedures. This analysis sheds some light on the possible effects of these varied contact services.[2]

An analysis of the services provided by the SWs as outlined earlier (that is, contacts with other personnel and organizations with the SW intervening as an agent for the client), based on the amount of contacts as compiled from the records of phone calls and interviews did not show any major difference between the successful and unsuccessful groups. As it was felt that it would not be meaningful to look for a direct relationship between the total number of phone calls and the success of the client, the contact services were categorized on the basis of ranks. The general range for each of the various types of services was delineated then divided into three distributions of high, intermediate and low. The client was then ranked according to the number of contacts made on his behalf, or meetings with him, into the highest rank, III; intermediate rank, II; and the lowest rank, I.

C H A R T I

TOTAL PROCESS IN THE ILP

Problem Areas	Programs to Introduce Change	SW Intervention "Strategy"	Agency	Terminal Goals
NEED FOR CHANGE	Personality counseling (see Chart IV)			
<u>Institution</u>				
In pattern of living	Vocational training and employment . . .	SEE CHART II	. . . . . DVR	SEE CHART III MAINTENANCE WITHOUT PHYSICAL OR MENTAL DETERIORATION ECONOMIC INDEPENDENCE IMPROVED SOCIAL AND OCCUPATIONAL FUNCTIONING
	Family Environment . . "residence"		. . . Foster Home	
<u>Negative Environment</u>				
Family dis-function	Recreation		. NYSOH Camp Recreation Agencies	
Poor physical environment	Rehabilitation		. Rehabilita-tion Centers	
	Maintenance Services .		. . . . .	
	Monetary		. Dept. of Welfare	
	Special Equipment Transportation . . .		Private Services	
	Medical Services . . .		. Hospitals	

CHART II

SOCIAL WORK INTERVENTION "STRATEGY"

Programs	Intervention[1]	Expediting[2]
VOCATIONAL TRAINING AND EMPLOYMENT	Obtain interview Voc. training Special equipment	Receiving training. Schooling
FAMILY ENVIRONMENT (Residence)	Obtaining some service from foster mother	Physical alterations of the home
RECREATION	To obtain service	. . . . .
REHABILITATION	To obtain service	. . . . .
MONETARY	To provide for special needs; to get special equipment, clothing, transportation	Checks special allowances
	Approval of "housing"	(foster home)
SPECIAL EQUIPMENT	. . . . .	
TRANSPORTATION	Pickups and deliveries	. . . . .
MEDICAL SERVICES	Medication Appointments for clients	. . . . .

(continued)

[1]Intervening: doing something for client with another agency.

[2]Expediting: getting services for client more quickly.

CHART II (continued)

Interpreting[3]	Information[4]	Problem Areas
Personal background Current motivation	Attitude	Delays Confusion over services offered
Client's actions and criticisms	Client's specific needs	Physical environment Foster Mother's attitude, style of life
Client's limitations	Needs Personality	Recreation agency unable to integrate client
Special problem	Objective	Time lag
Eligibility for special needs	Areas of client's allocation of funds	. . . . .
criteria for making residence acceptable.		
. . . . .	Type	Delays
. . . . .	. . . . .	Long waits
Details of medication	Personality	Re: hospital

[3]Interpreting: focus on problem or needs for agency or client.

[4]Information: obtaining data.

CHART III

INTERAGENCY RELATIONS

Agency Type	Personnel	Problem Areas
DVR	Vocation counselor	Role confusion " conflict " identity
FOSTER HOME	Foster Mother	Dif. client's rights services to be provided
NYSOH CAMP (Receiving Agency)	Social work camp intake worker Agency group worker	Differences over eligibility. Refusal to integrate clients
REHABILITATION CENTERS	Rehabilitation Counselor	Immediacy of need for rehabilitation
DW	Welfare caseworker	Interpretation of client's needs. Role conflict. Differences over client's personality. Acceptance of Foster Home.
PRIVATE SERVICES	Driver	Treatment of client. Delays in transporting client.
HOSPITALS	Medical social worker Doctor	Client's medical needs. Need for hospitalization.

The cutoff points were based on an arbitrary choice, after viewing the distribution so that the extremes would represent a difference great enough to indicate distinctly dissimilar types of service. This was done because many of the categories could not be accurately assessed as to service rendered, for example, a telephone call that takes an hour could be equated with two that are shorter. The analysis included the months prior to placement and three months during placement (see Table 7.4, below, and Tables 7.5, 7.6 and 7.7, pages 160 and 161).

TABLE 7.4

CLASSIFICATION SCHEME FOR NUMBER OF SOCIAL WORK CONTACTS

Rank	Contacts* TCL	VCL	TC	TPF	VFH	TFH
3 mos. pre-placement:						
Rank I	0-2	0-2	0	1-4	0-1	0-4
" II	3-8	3-5	1-3	5-12	2-3	5-9
" III	9+	6+	4+	13+	4+	10+
3 mos. in-placement:						
Rank I	0-3	0-2	0-1	0-6	0-2	0-4
" II	5-9	3-4	2-5	7-18	3-4	5-8
" III	11+	5+	6+	19+	5+	9+
6 mos. in-placement:						
Rank I	0-8	0-4	0-2	0-10	1-3	0-7
" II	11-17	5-13	3-8	11-25	4-8	8-13
" III	20+	15+	9+	26+	9+	14+

*TCL - telephone contact with client,
VCL - interview with client,
TC - telephone to collateral organization,
TPF - telephone contact with another professional,
VFH - visit to foster family,
TFH - telephone to foster family, usually foster mother.

TABLE 7.5

SOCIAL WORK CONTACTS DURING THREE MONTHS PRE-PLACEMENT*

Ranks	Number of Clients TCL	VCL	TC	TPF	VFH	TFH
Successful						
Rank I	14	13	15	7	15	9
" II	7	14	11	14	14	20
" III	11	5	6	11	3	3
Unsuccessful						
Rank I	11	12	12	7	12	7
" II	6	10	7	7	9	13
" III	8	3	6	11	4	5
Total						
Rank I	25	25	27	14	27	16
" II	13	24	18	21	23	33
" III	19	8	12	22	7	8

*See Appendix for further breakdowns.

One category was omitted from the classification of the various types of contacts made by the client, namely, "the client visiting the office." This category was left out because of the change in policy that occurred at the beginning stages of the program. At the outset, social workers would visit the clients in their foster homes rather than bring them to the office. After the first year, however, when the number of clients being served was greater, many clients were transported to the office to see the social worker. Although the differences in approach cannot be evaluated, information that was analyzed about the earlier stages of the program and the realization that "depth-therapy" was not feasible or served no purpose for most clients at this stage leads to the following conclusion: a visit to see the disabled client in the home environment is superior to an office visit. The opportunity to interact with the foster family, to work with foster mother and client together and individually, and to obtain a picture of the client in the setting,--all these provided the SW with a better opportunity to resolve some of the minor problems. Again it should be stressed that the allocation of the worker's time is an important factor in determining when a home visit should be made.

TABLE 7.6

SOCIAL WORK CONTACTS DURING FIRST THREE MONTHS IN PLACEMENT*

Ranks	Number of Clients TCL	VCL	TC	TPF	VFH	TFH
Successful						
Rank I	18	21	30	17	21	10
" II	9	10	5	16	12	18
" III	8	9	5	7	7	12
Unsuccessful						
Rank I	11	11	16	10	17	9
" II	7	6	4	8	2	8
" III	5	7	4	6	5	7
Total						
Rank I	29	32	46	27	38	19
" II	16	16	9	24	14	26
" III	13	16	9	13	12	19

*See Appendix for further breakdowns.

TABLE 7.7

SOCIAL WORK CONTACTS FROM THREE TO SIX MONTHS IN PLACEMENT*

Ranks	Number of Clients TCL	VCL	TC	TPF	VFH	TFH
Successful						
Rank I	21	23	32	20	22	16
" II	15	13	6	12	16	13
" III	5	5	3	9	3	14
Unsuccessful						
Rank I	12	17	17	13	22	7
" II	12	12	10	9	5	8
" III	6	1	3	8	3	10
Total						
Rank I	33	40	49	33	44	23
" II	27	25	16	21	21	21
" III	11	6	6	17	6	24

*See Appendix for further breakdowns.

Effectiveness of Counseling Procedures

To evaluate the "eclectic" counseling procedures of SWs, a system of categories (see Chart IV) was set up that could be used to classify the SWs' methods as determined from the casework records. In view of the individual nature of many of the problems, this approach was accompanied by a study of the types of problems the clients presented, to determine whether the procedures used were related to this factor.

The procedures were then compared with the degree of success of the client and with progress made in other areas. Some of the categories overlap since no attempt was made to make them mutually exclusive. Although some of the categories are related to certain "schools of therapy" the small number of cases and the lack of a clearcut difference among the approaches being used did not allow for a description of the content of the approaches in great detail. The factors chosen for inclusion in the analysis were based on a combination of principles suggested by others[3] regarding the types of relationships and counseling procedures that are beneficial to the client.

Data were taken from the casework records, and judgments were made by research psychologists on the basis of agreement as to appropriate categories which are discussed below. The global nature of the categories did not make judgments as difficult as might be expected; agreement in a large majority of the cases was possible.

1. Degree of independence. Dependency is one of the major negative personality attributes of the disabled. It was anticipated that the degree of independence the SW would allow her clients, and the relationship of this factor to the clients' disability and personality, would provide some information about the clients' progress and possibly their success. The SW was rated on whether she allowed clients to make most of the major decisions, some of the major decisions, or whether she made most of the major decisions for the client herself. Major decisions were defined as those involving the client's movement in an important area such as vocational choice or change, marriage, movement from foster home, or embarking on some new path such as going to school.

2. Orientation. The general orientation of the SW was characterized according to whether she used an approach that could be classified as "depth-analytical," by which she delved into the childhood and family background of the client, and with

CHART IV

PERSONAL COUNSELING BY SOCIAL WORKER

Factor			
Independence	Majority decisions made by: 1 Social Worker	2 Shared	3 Client
	- refers to areas of Work, Education, Marriage		
Orientation	1 Depth-analytical (psychotherapy)		2 Reality-Pragmatic (focus on solution to current reality problems)
Involvement Time element - Energy investment -	1 Intense Meet client at varied locations	2 Moderate	3 Clinical Infrequent meetings mainly at office
Area of Focus (topics discussed with client)	1 All Work, Education, Sex. Interpersonal, Disability	2 Major (generally work and interpersonal relations)	3 Limited (focus on an immediate problem-did not relate to a general area

him, analyzed his behavior and personality problems in an attempt to assist him in gaining insight into current behavior patterns. This emphasis on personality modification and on a verbal approach is one means of psychotherapy. The other orientation was categorized as "reality-pragmatic," that is, one focusing mainly on current problems confronting the client (in the area of work, recreation and making practical environmental adjustments), as well as providing the client with information and guidance of a supportive nature. Here, few efforts were made at discussing the client's past behavior as a key to understanding current behavior or problems. The goal was to help the client meet his overwhelming immediate needs.

3. Environmental involvement. This factor focused on the relationship between the client and the SW outside of the office. It measured the degree to which the SW interacted with the client by frequent visits to the hospital (or, after placement, to the foster home), or to the client's place of work or other meeting places, taking the client out to a restaurant, store, or a ball game, attending a client's wedding or other celebration, or accompanying the client to another agency or facility. The worker would also be available at almost any time, and would make frequent contact with the client; in emergencies, she would personally go to his assistance. The categories of involvement were labeled as: (a) intense, (b) moderate, and (c) clinical, the latter category implying a relationship in which the SW generally did not see the client in any location other than the office or the foster home, and then, only infrequently.

4. Area of focus. In a number of cases, the SW focused on only a few major problems, such as work or some other "limited problem area"; concentrated with the client mainly on resolving problems in this area, and did not touch on other areas. This was categorized as a "limited problem areas" orientation. When the SW discussed most of the problems confronting the client, ranging from work to recreation and relationships with the foster mother, the orientation was seen as encompassing "general problem areas" or most of those that confront the average client. If, however, the SW discussed every aspect of the client's life, including, for example, sexual and other "taboo" areas,

the area of focus was seen to include "all problem areas."

These categories were established after the entire case records had been read completely, and on the basis of discussions with the SWs regarding the counseling of clients. As a consequence of the differing views held by the SWs regarding major themes, the possibilities for analysis in this area were recognized and developed.

Although the categories are not mutually exclusive and are quite general in scope, two raters, as noted above, were able to classify the case records with a high degree of concurrence. Further analysis will also indicate that the global ratings were also highly accurate (see Table 7.8, below and Tables 7.9, page 166 and 7.10, page 167).

TABLE 7.8

PRE-PLACEMENT COUNSELING PROCEDURES AND SUCCESS

Procedure	Per Cent Successful (N = 43)	Per Cent Unsuccessful (N = 31)
Orientation: Depth-Analytical	26	23
Involvement: Intense	30	28
Area of focus: All	30	26
Degree of independence: client makes most decisions	23	23

TABLE 7.9

IN-PLACEMENT COUNSELING PROCEDURES, WORK AND SUCCESS

Procedure for Successful Clients	Work No.	Work 100 p.c. equals	Non-work No.	Non-work 100 p.c. equals
Orientation:				
Depth-analytical	11	14	2	5
Reality pragmatic	15	20	15	35
Involvement:				
Intense	10	13	5	15
Moderate and Clinical	17	22	11	24
Age of Focus:				
All areas	12	16	3	8
Major or limited	14	18	14	32
Degree of Independence:				
Client decides	7	10	5	12
Shared decision making	19	24	12	28

Personnel Who Worked With the Disabled

The shortage of professionals to work with the physically disabled is probably the reason for the absence of studies on the characteristics of personnel who are most successful in achieving positive results in such work.

And yet despite the many difficulties that are involved in this type of undertaking, such research would be valuable in determining, for example, if more qualified types of professionals could obtain better results even with a large caseload.

The analysis in this section is not an attempt to provide answers concerning the type of personnel that is best equipped to work with the disabled or is more successful in aiding the disabled to adapt to community life. Rather, it is a response to the opportunity to determine if certain of the social workers did achieve success with a greater number of clients than was usual, and if there were any differential factors that could be isolated for study and investigation.

TABLE 7.10

PRE-PLACEMENT COUNSELING PROCEDURES IN RELATION TO VARIOUS FACTORS*
(N = 74)

FACTOR	PROCEDURES: Orientation		Involvement			Area of Focus			Independence		
	Per Cent		Per Cent			Per Cent			Per Cent		
Onset of illness:	D	R	I	M	C	A	M	L	C	S	SW
Congenital	8	35	16	20	7	16	22	5	4	36	3
Non-congenital	16	41	18	30	9	12	27	18	19	36	1
Mobility:											
Wheelchair bound	8	20	5	15	8	9	12	7	8	20	0
Ambulatory	16	56	28	35	8	19	36	16	15	53	4
Age:											
Under 35 years	19	36	19	27	9	22	26	8	8	45	3
Over 35 years	5	39	15	23	7	7	23	15	15	29	1
Disability:											
Cerebral palsy	8	31	14	19	7	16	18	5	3	34	3
Non-cerebral palsy	16	45	20	31	9	12	31	18	20	39	1
Education:											
H.S. Grad. Plus	14	27	15	22	4	15	19	7	8	31	1
Some H.S. and Less	11	49	19	28	12	14	30	16	15	42	3
Intelligence:											
High I.Q.	5	15	7	12	1	4	9	7	7	14	0
Normal I.Q.	16	42	22	29	8	20	14	12	14	43	1
Low I.Q.	3	19	5	9	7	4	14	4	3	16	3

*Orientation: Depth-analytical, Reality pragmatic; Involvement: Intense, Moderate, Clinical; Area of focus: All problem areas, Most problem areas, Limited problem areas; Degree of independence: Client makes most decisions, Client and SW Share decisions, SW makes most decisions.

Although many studies have been made in an attempt to identify the personality types that are most successful in the area of psychotherapy, and other studies have focused on the personality characteristics of people who enter various occupations, there is almost no information in these areas on persons who work with the disabled.

Relation of Success of ILP Client to Particular SW

A breakdown of the ILP clients according to degree of success shows the distribution amongst the SWs in Table 7.11. The results illustrate the differential success and a possible relationship between the type of SW and the client's adjustment in the community.

TABLE 7.11

DISTRIBUTION OF ILP CLIENTS ACCORDING TO SUCCESS AND PARTICULAR SOCIAL WORKERS (N = 74)

Social Worker	Clients			
	Successful		Unsuccessful	
	No.	Per Cent	No.	Per Cent
A	13	72	5	28
B	6	67	3	33
C	6	50	6	50
D	6	55	5	45
E	5	45	6	55
Other SWs*	7	54	6	46

*Had one or two cases each.

A more detailed analysis of the differential success of the social workers was performed by ascertaining if there were differences among the SWs when controlling for the variable of work. The distribution in Table 7.12, page 169, indicated that "A" retains a high percentage of clients who are successful, even though they are not working.

TABLE 7.12

DISTRIBUTION OF ILP CLIENTS ACCORDING TO SUCCESS IN PLACEMENT, WORK AND SOCIAL WORKER

Social Worker	Successful		Unsuccessful	
	Work	No Work	Work	No Work
A	8	5	1	4
B	5	1	1	2
C	3	3	1	5
D	4	2	3	2
E	4	1	1	5

Although there is not sufficient information to determine the role played by the SW in assisting the client to find work, or in working with the client so that he was motivated to find employment through the Division of Vocational Rehabilitation, "A" had almost half of her clients working.

Another measure of SW effectiveness was the number of environmental changes made by the client and the location to which he moved. The results, as indicated in Table 7.13, page 170, continue to show a general consistency in the differences in the effectiveness of the SWs, particularly "A" and "E."

Distribution of Client Types

Before investigating the possible reasons for the differential success, there was an analysis of the distribution of types of clients assigned to each of the SWs (see Table 7.14, pages 172-172). Although an earlier analysis did not indicate any relationship between various characteristics of the clients and success in the community, it was possible that a lopsided assignment of various types to one or two SWs could have accounted for the differences found.

The types of clients assigned to the SWs, as categorized by the factors listed in Table 7.14 illustrate the similarity of the various types of clients. The few differences found indicate that "A" and "E" had a population that

TABLE 7.13

DISTRIBUTION OF CLIENTS ACCORDING TO SOCIAL WORKER AND NUMBER OF ENVIRONMENTAL CHANGES AFTER PLACEMENT

Social Worker and Time in Placement	No Change	Change of Location to: Out of Project*	New Foster Home	Indep. Living
0-6 months:				
A	13	3	3	0
B	5	3	1	2
C	10	3	3	2
D	10	1	2	0
E	9	2	5	0
F	4	0	1	0
G	5	2	0	0
H	4	0	1	0
6 mos. - 1 year:				
A	10	0	3	0
B	5	0	0	0
C	6	2	1	1
D	6	2	0	2
E	6	3	3	0
F	4	0	0	0
G	0	1	1	1
H	0	0	0	0
1 - 2 years:				
A	7	2	0	0
B	5	0	0	0
C	3	0	0	0
D	3	2	2	2
E	6	1	1	1
F	2	0	0	0
G	1	0	0	0
H	0	0	0	0
2 - 4 years:				
A	6	1	0	1
B	3	2	0	1
C	3	0	0	0
D	6	0	0	1
E	2	0	0	0
F	1	0	0	0
G	0	0	1	0
H	0	0	0	0

*Left project or moved to unsatisfactory environment.

TABLE 7.14

PER CENT DISTRIBUTION OF ILP CLIENTS TO THE SOCIAL WORKERS ACCORDING TO VARIOUS FACTORS

Factors	SOCIAL WORKERS A (N=18) p.c.	B (N=9) p.c.	C (N=12) p.c.	D (N=11) p.c.	E (N=11) p.c.	Others (N=13) p.c.
Disability						
Polio	11	11	8	0	18	0
Cerebral palsy	33	22	50	45	45	31
M.S. & M.D.	11	0	0	9	9	15
Other Neural disorders	11	33	33	0	0	0
Arth. & joint diseases	6	22	0	18	0	8
Spinal Defects	11	11	0	0	9	23
Amputation	11	0	8	0	9	8
Paraplegia (non-polio)	6	0	0	3	0	0
Age of Onset						
Birth	39	33	50	45	55	46
Under 5 yrs.	6	0	8	0	0	0
5 - 10 yrs.	6	22	0	0	18	8
11 - 15 "	0	0	0	0	0	8
16 - 21 "	17	0	0	18	0	8
Over 21 "	33	45	42	36	27	30
Mobility						
Wheelchair	61	33	33	36	55	15
Ambulatory	39	67	67	64	45	85
Eating						
Independent	61	88	58	91	82	62
Needs Help	39	12	42	9	18	38
Bathing						
Independent	55	55	58	45	45	77
Needs Help	45	45	42	55	55	23

(continued)

TABLE 7.14 (continued)

Factors	SOCIAL WORKERS A (N=18) p.c.	B (N=9) p.c.	C (N=12) p.c.	D (N=11) p.c.	E (N=11) p.c.	Others (N=13) p.c.
Toilet						
Independent	89	100	83	100	100	100
Needs Help	11	0	17	0	0	0
Dressing						
Independent	45	78	75	82	55	85
Needs Help	55	22	25	18	45	15
Race						
White	72	89	100	82	64	77
Negro	22	0	0	18	9	15
Other	6	11	0	0	27	8
Age						
Under 25 yrs.	28	11	33	9	55	31
26 - 35 "	28	67	17	36	18	8
36 - 50 "	38	11	17	18	27	54
51 - 60 "	6	11	33	36	0	8
Education						
College Grad.	6	0	0	0	9	0
Some College	0	22	8	9	0	8
H.S. Grad.	28	22	25	36	45	23
Some H.S.	28	33	25	27	0	38
Grade Sch. Grad.	28	11	25	27	45	30
Some Grade Sch.	11	0	17	0	0	0
Religion						
Protestant	11	0	8	36	9	15
Catholic	50	56	75	36	73	54
Jewish	38	44	17	27	18	30

was somewhat more disabled and that "E" had a younger and somewhat better educated population of disabled adults mixed with the other extreme, namely, a poorly educated group.

Social Work Differences

In view of the differential success rates of the SWs', an analysis of the data was made to ascertain any differences in the counseling procedures or number of contact services among the SWs. In addition, a number of other measures were used including the SWs' perception of clients, to provide further information about the procedures of SWs in this study (see Table 7.15, page 174).

An analysis of the counseling procedures utilized by the SWs during the first six months the clients were in placement indicated that there was a distinct difference in the types of approach. SWs "A" and "D," for example, fostered a greater degree of independent action on the part of the client, whereas SW "B" used a "depth-orientation" technique to a much greater degree than the others.

The next procedural question was whether this counseling typified a rigid approach on the part of the SW or was instead a flexible approach related to the real needs of the client, for example, using reality-oriented approach on a severely disabled client.

In view of the generally similar distribution of types of clients among the SWs, and the large differences in the types of counseling procedures used by the SWs, it can be concluded that there was a distinct difference in the working "styles" of the SWs in this program.

SWs Effectiveness and Service Contacts

The service contacts of the SWs (as outlined earlier) were set up in a system of ranks for further analysis. A total mean score for each client was obtained from the sum of the ranks of each type of service contact (see Table 7.16, page 175).

The service contact scores illustrate the variations among the SWs in the number of contacts made with or on behalf of clients. It is interesting to note that SW "E," with the lowest percentage of successes, also has the lowest mean score (indicating the smallest average number of service contacts). However, SW "C" with the highest average number of contacts, does not show an appreciably greater percentage of successful clients.

An analysis of the services received by the clients (see earlier section) indicated that there was no significant relationship between the quantity of services received and success achieved.

TABLE 7.15

SUMMARY OF SOCIAL WORK PROCEDURES* ACCORDING TO PARTICULAR WORKER

Social Worker	Total N	Orientation Per Cent		Involvement Per Cent			Area of Focus Per Cent			Deg. of Indep. Per Cent		
		D	R	I	M	C	A	M	L	C	H	SW
Pre-placement												
A	20	30	70	25	50	25	20	60	20	40	60	0
B	12	67	33	75	17	8	58	42	0	8	92	0
C	11	0	100	36	55	9	27	55	18	9	73	18
D	11	36	64	45	45	10	46	27	27	27	73	0
E	11	0	100	0	82	18	0	63	37	9	91	0
In placement 6 months												
A	18	17	83	28	44	28	28	44	28	56	44	0
B	9	67	33	78	22	0	67	33	0	11	89	0
C	13	23	77	54	31	15	31	38	31	15	77	8
D	10	30	70	30	70	0	40	50	10	40	60	0
E	11	0	100	9	64	27	0	64	36	0	100	0

*Orientation: Depth-analytical, Reality pragmatic; Involvement: Intense, Moderate, Clinical; Area of focus: All problem areas, Most problem areas, Limited problem areas; Degree of independence: Client makes most decisions, Client and SW Share decisions, SW makes most decisions.

TABLE 7.16

MEAN AND STANDARD DEVIATION OF SOCIAL WORK CONTACTS (BY RANKS) BY SOCIAL WORKER AFTER THREE MONTHS IN-PLACEMENT

Social Worker	Mean	Standard Deviation	Successful Clients p.c.
A	1.66	.82	72
B	1.70	.65	67
C	1.85	.84	50
D	1.61	.85	55
E	1.43	.57	45

Mental Health Status

Another measure of the SWs effectiveness was introduced. This measure combined the client's rank in the areas of personality organization (PFCS), interpersonal relations and the client's subjective view of his mental health. In Table 7.17, below, a rank of 1 indicates "highest level" of mental health.

TABLE 7.17

DISTRIBUTION OF CLIENTS ACCORDING TO SOCIAL WORKER AND MENTAL HEALTH STATUS

Social Worker	RANKS 1	2	3
A	9	3	6
B	4	2	3
C	3	3	6
D	5	2	4
E	3	2	6

This measure supports the results found when using other measures of success. SW "A" consistently shows the greatest number of successes, whereas SWs "C" and "E" show the lowest number of successes.

SWs and Interperson Perception

Unfortunately, the ILP was not designed to provide detailed information about the effectiveness of the SW or the personality features of the SW that contributed to this effectiveness.

In view, however, of the differential success of the SWs, and the belief that investigation of the characteristics of those who work with the disabled can provide useful data about "effective types," an analysis in greater detail on the differences that appeared on the forms completed by the SWs was performed. It soon became apparent that there was a major distinguishing feature between the other SWs and SWs "C" and "E," namely, a difference in interpersonal perception. SWs "C" and "E" showed a distinct tendency to use a restricted range in their description of the clients' personality (on the PFCS) difficulties, and tended to use the midpoints of an adjective rating scale as can be seen in Table 7.18, below.

TABLE 7.18

MEAN SCORES OF SOCIAL WORKERS
ON ADJECTIVE RATING SCALE

Social Worker	Mean	Standard Deviation
A	1.49	.61
B	1.79	.83
C	1.29	.53
D	2.00	.78
E	1.34	.67

A typology of the social workers was established on the basis of qualitative materials gleaned from interviews with them, and from the Research Director's reading of the case records (as well as on the data previously presented).

Although there were a number of distinctive features that typified each of the social workers, a major factor that clearly divided the group was the complexity with which they viewed the clients, that is, the ability to perceive the personality characteristics of the clients with some depth and to comprehend the dynamic interaction of the various traits.[4]

No attempt has been made to go into great detail because of the limitations mentioned previously. In view of the large number of personnel, rehabilitation or vocational counselors, medical social workers and others, who work with the client in planning for the client's future and who play a major role in aiding his adaptation, it would appear that further investigation along the lines outlined here would prove fruitful.

Group Counseling

Another role that was played by the SW in the ILP was that of group leader in counseling sessions. No specific data was gathered and analysed but this service was enthusiastically received by the clients who participated and should therefore be described.

During the third year of the project a group was formed of clients living in foster homes, with the goal of working on problems in common in a different way than could be handled in the one-to-one counseling periods. In the fourth and fifth year, two groups met. There were five to eight clients at the meetings.

At first, the group acted as a social event for these comparatively isolated clients--often isolated after placement from other disabled people. The integration into the community after spending years in a hospital was often sudden and unless some work or training plan were initiated immediately, the client felt "lost."

As the group members became more comfortable together, they shared more of their problems ranging from criticism of the foster family, of their SW in the agency, of their medical care and of their budgets, to problems of the future; these included: living plans, marriage plans, also what work they could do, what training was available and what chance there was of ever really being accepted in the community.

Group counseling was considered to be a step towards greater independence in the area of personal guidance. During the last year of the project, the members of one group did not have a "private" SW, but brought all problems to the weekly group sessions. It is interesting to note that in the opinion of the group SW, those members who had considerable casework on a one-to-one basis with a SW were able to make greater use of group discussions than those who had only limited casework service. It might have been thought that those who were used to being able to call on a SW for assistance at any time would have been more reluctant to share personal information and feelings and would have found it more difficult to postpone the discussion of problems until the meeting date.

Discussions were conducted on a simple, direct and practical level. Some time was given, for instance, to ways of hailing a taxi if you are wheelchair bound; to ways of approaching social workers in other agencies (in the "advance" group, these contacts were all made by the client); to getting the foster mother to change a routine or serve different kinds of food. All of these subjects were of course previously discussed in the one-to-one interviews but the chance to share ideas about the solutions added to the maturity of the clients. The recording of the group sessions showed chronological movement from one subject to another so that process and dynamics could be traced through each meeting.

Since there was a great deal of discussion regarding problems of living when the clients first moved into foster homes and had one SW, it is interesting to see how the clients approach these same problems on a group level when they are beginning to think of more independent living than a foster home--such as, their own furnished room or small apartment or sharing an apartment. (The "I" in the recording is the SW.)

> "When we were ready to start, I mentioned that Wendy had some special pressing problems she was working on and that I thought we could have her discuss it today and wondered if there was anything else somebody had that they felt was urgent for today. They thought Wendy ought to go into her problem.
>
> "Wendy said her problem was finding a furnished room. She had been to Department of Welfare (DW) and that is what they told her she was to do. She wondered how she would find one. Ruth suggested looking in the newspapers and trying real estate agents. Kathy asked what location she was interested in. Wendy said either the Bronx or Manhattan. Betty wanted to know what part of the Bronx, and Wendy thought the East Bronx. Betty asked Wendy to be more specific since there were parts of the Bronx that were as inaccessible as far as transportation is concerned as Long Island. Wendy said she was aware of that and would seek a place that was near public transportation. In general, the girls were asking some fairly good questions of a practical nature. I told Wendy that I was interested in what she initially said about the DW worker telling her that she had to get a furnished room. I wondered about how that decision came about, and whether she thought about it as opposed to any other kind of living arrangement. I learned that she had asked him about an apartment last week. He said that DW would not want to establish somebody who was single in an apartment. It would entail furnishing

an apartment--what if she lived there for a short time, got married, and decided she wanted to live somewhere else. He said they would pay $15.00 a week for a furnished room for her. I asked Wendy if this was what she really wanted. She said, she wanted an apartment. I also inquired if this was really her only alternative--a furnished room--or had she considered other kinds of living arrangements? I thought that this was a very important question she had to answer for herself before she actually set about looking for something. Kathy asked if she considered living in a residence or in a hotel. She said she couldn't manage a residence because of carrying a tray independently. She had considered the "Y" but they do not take handicapped people; especially, those with crutches. I asked if there were any other alternatives anyone could think of. When there was no response, I asked if she had considered a furnished apartment? She said she hadn't thought of that but that if they would pay for it she thought that was better than a furnished room.

"Wendy told about having gone to see her priest in Brooklyn to ask him if he knew of any place where she could live. He said he didn't but referred her to a real estate agent down the street whom she contacted. The agent asked her if she was working. When she explained she was not working and was on welfare, he did not seem to be interested in talking further. There was some discussion about the difficulty welfare clients might have in finding places and that the same was true too for handicapped people. They talked about the difficulty they had with people being concerned about having handicapped people in their apartment houses or rooming houses because of some misconceptions there might be about them. Also the fear of responsibility--thinking they might need some help or might fall. They talked about the difficulty, too, if in addition the person received welfare assistance. Kathy said she knew of people who did find places. She mentioned a real estate agent in the neighborhood. She told Wendy the location and said she would get the exact name and address for her. Wendy also wanted to know if she would have to pay the real estate agent. We told her that generally the landlords do pay the fee but she could inquire of each place before she registers.

"I then went back to the incident when she spoke to the agent over the phone. I said that I wondered

what Wendy could say that would be honest yet would make it possible for her to get a place. Kathy said that she thought that Wendy should ask for an interview before telling very much. She felt that if a person met Wendy, talked with her, and saw what kind of person she was, they would be more likely to find her a place than if they did not see or know her and only heard a phone voice. This seemed a good suggestion and the others agreed that a personal interview would be better.

"I came back to the question of what Wendy could do that was different than she did last time. She said that when she was asked, she had to tell she was on welfare. I said that as she related the incident, it seemed she was not asked, but volunteered the information. She went over the incident and could see, although she was sure before that he had asked, all he did ask was "Are you working?" Wendy said she could have told him that she is not working now but she had been working before. I added, that he was interested in her ability to pay the rent and whether she was a dependable person. She could have said that she is not working at present. She was just moving to the city, but she had lived and worked on Long Island. She could truly say this since she was employed for over two years at the workshop. She could also have added that she would not have any difficulty paying the rent. All of this would have been the truth. There was some discussion about this and how it was important to present one's self in the best light and being self-confident.

"I thought the next thing Wendy ought to consider which I assumed she already had, was the whole question about living alone. Was this something she was interested in doing? Betty, Brenda, Kathy and Ruth were all very definite in their feelings that they would not want to live alone. They would be too lonely. Brenda told about having lived by herself for a short while in a hotel and how she always used to have the radio on just to hear somebody. She said she got so sick and tired of that radio she wanted to throw it out. She was very dramatic and funny when she told this and members of the group laughed. Kathy wanted to know from Wendy how she had come to the decision and what her plans were about living by herself. Ruth then said she wondered what would happen if Wendy became ill and needed somebody to take care of her. Wendy's reply was that she would use the telephone. Teresa said that it would worry her being alone if she were not well.

She used the term "worry me." She spoke appropriately and with feeling to this point. Everyone seemed to be in agreement that living alone would not be suitable for them.

"I then raised a question of whether people were using the terms "living alone" and "living independently" as though they were the same. Did they consider living alone as the highest step of independence? I wondered since we have been talking about reaching various stages of independence, they were under the impression that we may have meant that living alone was the goal. Kathy said that she didn't think they were the same at all. She talked about a person's independence having to do with what he can do for himself and how he manages his affairs. Ruth said that she knows some people who live by themselves but wouldn't consider them independent at all. They live alone but they are very dependent on others coming in and doing various things for them. Betty told how she is more independent in many ways in a foster home. When she was home, everyone had to do things for her. Now she can go out by herself, come and go, and not be involved with anyone else. I talked about people choosing to live with other people even though they can manage to live by themselves. I said I was referring not especially to handicapped people but to any people. Many people do prefer and choose to have a roommate whom they feel is companionable. They might prefer this to living alone. There was some discussion about people's preference in this matter. Wendy said if there was somebody whom she thought was companionable, she would prefer to have a roommate. At present, there seems to be no one amongst her friends whom she thinks would work out if they lived with her. This admission came after a great deal of talk by the other girls as to why they would not want to live alone. Wendy had said very little about her own feelings of living alone except that she would be busy going to school, and so forth. She would also meet people where she lived. Betty had talked too about Brenda living alone in a hotel and of the long hours she spent on the phone when Brenda would call, telling her that she was hearing voices. She attributed this to her being alone.

"This week the group got down to business very quickly. They seemed to feel the urgency for getting things done. They were very serious about Wendy's problem and helped her with it. Although Wendy did not say

very much about her feelings of living alone, she could not help but be impressed by the other girls' strong feelings and statements in this area. At the end of the session, her admission that she had considered living with a roommate was the only time she admitted to any conflict in the area of living alone."

REFERENCES

[1]In Edgar F. Borgatta, David Fanshel, and Henry J. Meyer, Social Workers'--Perception of Clients (New York: Russell Sage Foundation, 1960), the authors have also noted:

"Many important outcomes of casework service may depend less on understanding and effecting changes in clients as persons and more on understanding and effecting change in their social environmental situations. For such understanding, knowledge about families, peer associations, community institutions, and many forces and obstacles will be necessary. The professional skills required to change such factors may implicate the agency as an organization and, indeed, the whole complex of social welfare and civic institutions in the community. Such efforts will engage social workers other than caseworkers, as well as persons from other professions and from other segments of community life.

Such an overwhelming prospect should not minimize the importance of the more narrowly conceived function of individual casework, which must always remain an important approach to helping people with problems. We merely recognize that casework occurs in a wider context. Within casework the generalized description of clients for diagnostic and evaluative purposes must proceed, we believe, along some of the lines discussed in this monograph. We have stressed the fact that research with this purpose has been relatively scarce even though it would seem to be at the core of professional casework. Although we have recognized both the limitations and the problems of studying the casework enterprise, the emphatic conclusion of our study is that detailed and systematic descriptive research in this area will be productive for the profession."

[2]Few detailed breakdowns of the types of services provided by social workers are available. One suggested framework, although utilized in a "time analysis" study, appears in: John G. Hill, Ralph Ormsby, and William B. McCurdy, Time Analysis Manual--Procedures for Time Analysis in Family Service Agencies Including Those Which Provide Child Welfare Service (New York: Family Service Association of America, 1962), p. 43.

[3]The problems in evaluating the effectiveness of caseworkers efforts have been discussed in various articles. See for example:

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Maas, H.S., and Wolins, M. "Concepts and Methods in Social Work Research," New Directions in Social Work, C. Kasius, ed. (New York: Harper & Brothers, 1954), pp. 215-237.

Meyer, Henry J., Borgatta, Edgar F., and Jones, Wyatt C. Girls at Vocational High--An Experiment in Social Work Intervention (New York: Russell Sage Foundation, 1965).

Shyne, Ann W. "An Experimental Study of Casework Methods," Social Casework, Vol. XLVI, No. 9 (November, 1965).

Report from a Staff Committee of the Community Service Society of New York, "Method and Process in Social Casework" (New York: Family Service Association of America, 1958). A schema, somewhat similar to ours, was used by Diller, who classified the kinds of services as follows:

"(1) no service, (2) information giving or concrete manipulation of reality, (3) supportive therapy, (4) planning for the future, and (5) examining self-destructive or neurotic patterns of behavior." Leonard Diller, "Psychological Theory in Rehabilitation Counseling," Journal of Counseling Psychology, Vol. 6 (1959), pp. 189-193, and in A. Jacobs, E. Jordon, and S. DiMichael, eds., "Client Counselor Relationships," Counseling in the Rehabilitation Process (New York: Columbia University, Teachers College, Bureau of Publication, 1961).

[4]For a detailed discussion of Interperson Perception see: Phillip E. Vernon, "Perceptions and Misperceptions of People," Personality Assessment: A Critical Survey (New York: John Wiley & Sons Inc., 1964), Chapter 2.

Also Joseph S. Vannoy, "Generality of Cognitive Complexity--Simplicity as a Personality Construct," Journal of Personality and Social Psychology, Vol. 2, No. 3 (1965), pp. 385-396, included a detailed bibliography

CHAPTER VIII

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

After analyzing the various factors that might have affected the disabled adult's adaptation to community life and to adjustment to a foster home, it became readily apparent that the study focused a large number of variables. The foster home was seen as only one of the many possible influences on the client's ability to sustain himself in the community. To determine the relative strength of each of the many variables was not possible because of problems in methodology and other related difficulties.

The results were, however, analyzed, based first on a number of hypotheses that had been developed and then on a general analysis of the various factors without controlling for alternate explanations.

It is in this light that the summary of findings is presented, with the hope that they will provide some additional answers to the problem of determining the factors that affect the adaptation of disabled adults to community life.

In the discussion the implications of the results are given and they include observations based on the years of work with these disabled individuals.

It is believed that the recommendations are specific and deserve immediate consideration in view of the many gaps that have been uncovered in the provision of services to

disabled adults.[1]

It is hoped that the complexity of the report will not dissuade anyone from reading it in its entirety and that the broad range of the investigation will help to provide some direction to those who are working in this field.

I. DESCRIPTION OF THE PROJECT

The basic objective of the Independent Living Project (ILP) was "to test the feasibility of a foster home program as an alternative to unnecessary in-patient care of adults with orthopedic disability." To achieve this objective, a research-demonstration project was established, and focused on two groups of physically disabled young adults for whom facilities for successful community living were hitherto unavailable.

The first group in the project consisted of persons who were occupying beds in various institutions and who could not be discharged despite the fact that they no longer required hospitalization. Numerous studies have indicated that there were many disabled who fell into this category.

The second group consisted of persons who were living in the community under such unsatisfactory circumstances that they were expected eventually to deteriorate and require some type of institutional care. Many physically handicapped in this large urban community were living at subsistence level in run-down hotels and rooming houses or with their families who were destructive in their attitudes and behavior to the handicapped person. Although this group was less visible than the other, it was felt their needs were similar to those of the

institutionalized group.

Residential Care

For both of these groups the major problem appeared to be the need for some type of residential setting. An examination of the various possibilities indicated that a special residential setting outside of the community was not feasible for many of the more severely handicapped, particularly those with cerebral palsy. An analysis of the type of environment that might be most beneficial to these potential clients led to consideration of the use of "family-type" environments. The principal problem of many of the handicapped adults was the need for both personal care and an environment that would overcome the isolation in which so many of the disabled find themselves. Further, it was felt that many of the disabled needed the emotional security that could be provided by integration into family life. In many cases, it was anticipated that by virtue of its own place in the community, a family could forge the social links for the disabled adult and thereby assist in his integration into community activities.

Intake Procedure

At the outset, hospitalized clients were generally recruited, or they volunteered for the program on the basis of information that was given to them by their social workers. Other clients, who came from unsuitable environments in the community, learned about the program through other agencies with which they had come in contact, or through their participation in the agency's camp for the disabled. The clients were seen by an intake worker who interviewed most of the clients before they actually entered the program. The intake worker filled out forms giving information about the client's general physical condition, needs and personality traits. This intake worker would also discuss the client's background with the social workers in the various hospitals or with others who might have information about him. In general, once the client passed this first screening, he was then accepted into the program and assigned to a social worker.

Homefinding

In the initial stages of the program, a large number of homes was obtained via mass media publicity. The homefinder visited the various families that were interested in becoming foster families, reported in detail on the physical setting of the home, and described the personality of the families, including any problems that might be encountered in placing clients in that particular home.

Board Rate

In some cases, physical modifications of the homes were made, the cost generally being paid by the New York Service for Orthopedically Handicapped (NYSOH). The foster families received $175 per month at the beginning of the program and later $200 per month. Fifty dollars of this amount was paid by NYSOH and the greater part by the Department of Welfare. When the client became employed, he contributed to the budget according to his ability to pay.

Matching Client and Foster Home

The social worker who was assigned to the client screened the various homes that were available and, after visiting some of the families, decided on the most suitable home. At this stage the social worker had met with the client a number of times at the institution or in other settings, including the agency's office, and had discussed his problems and needs. The clients filled out various forms for the research division and completed a number of tests. The foster families were also given forms and tests to complete and in some cases were interviewed by one of the members of the research division.

After the home was selected, the social worker arranged for a trial visit. The client stayed with the family for two or three days (usually a weekend), after which time the placement was discussed with both parties and evaluated. In many cases, if it was possible, the client remained with the family and arrangements were made for a permanent placement.

Counseling Service

The social worker was also available at all times to both the client and the family for any problems that might arise, and kept in close touch with the client and the foster family (generally by telephone) during the initial period of placement. At the same time, arrangements were made for the client to see counselors in various other agencies--the Division of Vocational Rehabilitation and agencies sponsoring workshops or recreational programs. Plans for the clients were discussed with them during this initial period and arrangements were made for the implementation of these plans.

When severe problems developed in any of the environments in which the disabled clients were placed, the social worker made arrangements to move the clients and planned for subsequent placement in whatever particular institution or

alternate environment available at that time. If absolutely necessary, the client was returned to a hospital or was placed in a nursing home. In some cases, the clients withdrew and made arrangements on their own.

Collection of Data

Information about the clients' adjustment and progress in the community was continuously compiled by the research division through a number of inventories and questionnaires that were filled out periodically, or for specific purposes by the social workers. They also kept case records of all of the meetings between themselves, the client and the foster family, and the issues that were discussed or problems raised were set down in great detail. Frequent discussions were held between the members of the research division and the social workers in order to obtain additional information about the general processes involved, and to feed back to the social workers any information that may have been obtained by the research division.

Cost of the Project

It was found that the project cost $211 per client-month of foster home placement. This was the cost of the entire project operation including the $50 per month supplementation to the Department of Welfare budget of $150 per month for board and room. (The foster family received $200 per month.) The Department of Welfare also gave an average of $25 per month for expenses such as personal needs and transportation. This means that the total cost of keeping a disabled person in a foster home was $211 + $175 = $386 per client-month--just under one-half the average cost of a patient-month in 1965 in the New York City hospitals giving chronic care. It is obvious that without the research component, the service cost would have been even less.

The increased opportunities for human development, supported so strongly by the marked financial saving, should commend to community planners everywhere this alternative to institutional existence.

II. FINDINGS

The following is a summary of the characteristics of the ILP clients and the foster families, of placement results and of the effects of social work intervention.

Characteristics of Clients and Foster Families

From hospital to community. The majority of referrals to the ILP were from voluntary hospitals, although the larger proportion of those disabled adults who actually became part of the program were from city hospitals.

Information obtained from interviews with the study-group clients indicated that they found community living far superior to institutionalization. Among the major reasons they cited for their negative view of hospital life was the regimentation, the absence of responsibility, boredom and the lack of opportunity to work. The disabled adults also felt that life in the institution gave them a sense of being divorced from the mainstream of life. Work with these clients showed that the institutions often failed to provide their inmates with a realistic picture of life in the community and with the necessary and appropriate interpersonal skills.

Although many of the disabled adults wanted to leave the hospital, there were many obstacles to the patient's discharge. The absence of a clear-cut administrative policy for the release of disabled institutionalized patients, the complicated bureaucratic procedures found in large institutions and the lack of coordination among the treatment staff frequently interfered with the discharge of the disabled patient. Other obstacles included: 1) the inability of the hospital social worker to spend adequate time in assisting the client to prepare for discharge, and 2) the role and interpersonal conflicts with the ILP social worker.

Origin and profile of clients and foster families. The clients who participated in this study came from institutions and "negative environments" in the community. A portion of the clients had been institutionalized for varying periods of time, and approximately 20 per cent of the group had spent more than ten years in hospitals. About one-third of the clients were cerebral palsied and approximately 35 per cent of the clients were wheelchair dependent. Almost 40 per cent of the clients needed some assistance in personal care, particularly in bathing. The population was about evenly divided between those who had acquired their disability in childhood and those who were disabled after adolescence. The educational deprivation was great. Less than 50 per cent of the clients had been graduated from high school. Few Negroes were referred to the study. This was apparently due to the attitude of Negroes toward private social agencies and the greater acceptance of their own handicapped members by Negro families.

There are apparently large numbers of institutionalized disabled clients who would be suitable for placement in the community. In the analysis of a comparable institutionalized group, it became evident that many of the potential clients were not aware of the ILP program. A small group could not accept the idea of living with a foster family, because it aroused latent feelings of anxiety about rejection by their own parents who were still alive.

Of the approximately 250 disabled persons referred to NYSOH, 74 (30 per cent) were placed in foster homes from September 1, 1961 until the cut-off placement date, April 1, 1965. Another 10 per cent received counseling services, and the remaining 60 per cent withdrew their applications, or were not accepted for various reasons. Statistics indicate that the study population was the most severely handicapped of the large number referred to the agency and in this sense the clients who were placed constitute an extreme group.

Of the approximately 15 per cent of the referrals who were rejected, the majority were considered by the hospital staffs as not ready for placement. The majority of clients who withdrew after they had been referred to the program either returned to their own families or made their own living arrangements.

A majority of the clients showed evidence of severe personality disorganization at the time of their placement in the foster home. This was not surprising in view of the fact that approximately 55 per cent of the clients came from broken homes or disturbed families. The characteristics of the type of home from which these clients originated showed the following distribution: severe psychopathology - 7; alcoholic - 11; divorced - 4; desertion - 4; physically ill - 7; dead - 5; separated - 3. Approximately 42 per cent of the clients were not brought up by their natural parents. Of these clients, 11 were raised by step-parents; 4 by foster parents and 16 spent their childhood in institutions.

Characteristics of clients from unsuitable environments in the community. On the basis of the numbers of disabled adults who were referred for placement, all indications were that there were probably large numbers of disabled persons whose need for services were not being met. The conditions under which many of the disabled adults who became clients were living were under highly unsuitable conditions, to say the least, which would probably have led eventually to the client's physical and mental deterioration.

Foster families. In regard to the effectiveness of foster family recruiting program, the mass media publicity

brought in many replies necessitating a tremendous amount of paper work but it did result in the initial acceptance of a large number of foster homes. The fact that not all of the accepted homes were used indicates that, prior to this type of appeal, there should be a large backlog of clients available for placement. Another factor which could reduce somewhat the number of unsuitable applicants would be the inclusion in the announcements of more detailed information about the types of homes that may be suitable and the type of work the foster parent may be required to do.

One of the key problems was that of finding homes that had a suitable physical environment for wheelchair clients, particularly homes with a bathroom which could accommodate these handicapped persons. Fully one-third of the foster homes offered were rejected because of the physical facilities which were found to be inadequate for any of the clients. Only a small number of foster families were rejected by the social workers because of unsuitable personality characteristics.

Among those responding to the agency's advertisements for foster homes, there was a heavy preponderance of upper lower-class to lower middle-class families. This group was mainly composed of women between the ages of 36 and 55 who were housewives and whose husbands were unskilled or semi-skilled workers with incomes of $7000 or less. Catholic and Protestant (mainly Negro) predominated, and they were found to live in one or two-family homes in communities composed mainly of such private homes. The first reason for applying cited by most foster families was financial, although many other motives were also mentioned.

Although most of the foster families who were willing to accept the disabled did not impose many restrictions on the types of clients they would accept, a composite picture of the type of client they most preferred was that of a woman, outgoing and warm, who could take care of most of her own needs, be neat, and not be frequently depressed.

The foster families who eventually became a part of the program were generally similar to the larger number of applicants who applied after the first inquiry. One apparent difference lay in the larger proportion of families in the age range 51 to 60 in the "initial inquiry" group; another difference was in the higher proportion of the study's foster-family husbands in the skilled occupational level.

In-Placement Results

It took an average of five months to place a client in a foster home. Although approximately 28 per cent of the

clients required more than one trial visit before being placed, there did not appear to be a factor common to either the clients or the foster families that could account for the need for additional trial visits.

Successful and unsuccessful clients. Clients were classified as unsuccessful if they showed evidence of physical and mental deterioration. The indicators used for this classification were the following:

(a) moved from foster home to unsuitable ("negative") environment;
(b) confined to psychiatric ward;
(c) returned to institution permanently;
(d) showed severe personality disorganization.

Of the 74 clients in the study, 44 per cent were classified as "unsuccessful." Most of the clients who failed did so within the first six months, with the vast majority failing at the conclusion of the first year of placement.

Vocational progress. About one-third of the clients were found to be working during their first six months in placement, with this number increasing with time. Disability itself was not the limiting factor for many in the population and a large number of the cerebral palsied were employed in workshops.

Advances in interpersonal relations. Nine per cent of the clients were married by the end of the first year. Approximately 20 per cent of those who remained in the program as long as one year described themselves as having fewer friends than in the pre-placement period. This was attributed to the clients' living in suburban homes. About 47 per cent of the clients showed an increase in vacation activities, particularly in attendance at a camp for disabled adults. This was probably due in part to the fact that the sponsoring agency operates such a camp. In contrast to the institutions from which half of the clients came, where vacations were discouraged for administrative reasons, foster families often welcomed clients' vacations as a respite from their duties and as an opportunity to take their own vacations. There was a general decrease in frequency of contacts with own family and relatives following placement.

Hospitalizations. Approximately 10 per cent of the

TABLE 2.5

COMPARISON OF EMPLOYMENT STATUS OF CLIENTS
AT SOME TIME PRIOR TO PLACEMENT WITH
EMPLOYMENT STATUS DURING PLACEMENT

Amount of Time Employed During Placement	Prior to Placement: Full Time	Part Time	Few Hours	None	Total No.	Total p.c.
0 to 6 months: N=74; No. working = 25 (34%)						
Full time	3	1	1	1	6	7
Part time	7	3	2	2	14	20
Few hours	1	1	1	2	5	7
None	30	2	1	16	49	66
Total	41	7	5	21	74	100
Left placement before 6 months	11	0	0	5	16	22
6 mos.-1 yr.: N=58; No. working = 23 (39%)						
Full time	5	3	1	2	11	19
Part time	4	2	0	0	6	10
Few hours	2	0	2	2	6	10
None	19	2	2	12	35	61
Total	30	7	5	16	58	100
Left placement 6 months - 1 year	5	1	1	0	7	9
No. in placement less than 1 year at termination of project	7	1	1	0	9	12
1 - 2 years: N=42; No. working = 25 (60%)						
Full time	5	3	1	4	13	31
Part time	3	1	0	2	6	14
Few hours	3	0	1	1	5	12
None	7	1	1	9	18	43
Total	18	5	3	16	42	100

clients required hospitalization for minor illness (remaining in the hospital for an average of 18 days) during the first six months in placement. This figure was not increased in the later stages of placement. Another 15 per cent of the clients entered hospitals for further physical rehabilitation during the first six month period for an average stay of three weeks. After the first six months a few of the same clients received further rehabilitation and those who had been in placement longer went in for minor rehabilitation.

TABLE 2.8

LOCATION OF CLIENTS ACCORDING TO TIME IN PLACEMENT

Time in Placement	Foster Home		Institution		Unsuitable Envir.		Indep. Living		Deceased	
	No.	p.c.	No.	p.c.	No.	p.c.	No.	p.c.	No.	p.c.
0-6 mos: (N = 74)	56	75	9	12	7	10	2	3	0	0
7-12 mos: (N = 58)	49	85	2	4	4	7	3	5	0	0
13-18 mos: (N = 47)	39	83	2	4	1	2	5	11	0	0
19-24 mos: (N = 35)	26	74	0	0	1	3	7	20	1	3
25-30 mos: (N = 29)	24	83	0	0	1	4	4	14	0	0
31-36 mos: (N = 23)	18	78	0	0	2	9	3	13	0	0
37 mos. +: (N = 20)	9	45	0	0	2	10	8	40	1	5

TABLE 2.9

LOCATION OF CLIENTS IN COHORTS ACCORDING TO TIME IN PLACEMENT AND PER CENT OF COHORT

Cohorts	Location*	Under 6 mos.	6 mos. - 1 yr.	1-2 years	2-3 years	3-4 years	4-5 years
Group 1:	F.H.	73	73	64	36	26	26
over 43 mos.	I.L.	0	0	0	9	19	19
(N = 11)	O.P.	27	27	36	55	55	55
Group 2:	F.H.	75	68	55	41	29	0
31-42 mos.	I.L.	4	8	8	17	29	0
(N = 24)	O.P.	21	24	37	42	42	0
Group 3:	F.H.	100	78	45	45	0	0
19-30 mos.	I.L.	0	0	22	22	0	0
(N = 9)	O.P.	0	22	33	33	0	0
Group 4:	F.H.	60	45	35	0	0	0
7-18 mos.	I.L.	10	10	10	0	0	0
(N = 20)	O.P.	30	45	55	0	0	0
Group 5:	F.H.	80	0	0	0	0	0
Under 6 mos.	I.L.	0	0	0	0	0	0
(N = 10)	O.P.	20	0	0	0	0	0

*F.H. = In foster home; I.L. = Moved to more independent living; O.P. = Out of the program, closed.

The first weeks: "Honeymoon" Period. The first few weeks of placement often found the client and foster family on their best behavior. Both parties made attempts to go out of their way to please and to avoid any areas of conflict, because of a strong desire to make the match work. Clients were less demanding and the foster parents were willing to overlook aspects of the client's behavior which they would ordinarily have found distasteful. This "honeymoon" period, however, did not last very long.

Clients' destination. Seventy-five per cent of the clients remained in the first foster home in which they were placed for the critical first six months. In this period, 12 per cent returned to institutions, 10 per cent moved to unsuitable environments in the community, and 3 per cent advanced to independent living. For clients in placement for

more than a year, there is a decrease in the proportion of those who were unsuccessful in the program, and an increase in the proportion entering independent living. The overwhelming majority of clients did not move into more independent living before having completed two years in placement.

The clients expressed various reasons for moving from foster homes. Four major complaints cited by clients moving from foster homes were:

(a) nagging and arguments by foster mother;
(b) friction over own family and friends visiting freely;
(c) unsatisfactory food;
(d) problems regarding use of the telephone.

Role of the social worker. The social worker in the project performed the following services:

(a) assisted in preparation of the client for community living;
(b) chose an appropriate foster home with the client;
(c) acquired physical aids and monetary support for the client;
(d) intervened for the client with many agencies and expedited receipt of services;
(e) provided counseling.

Obstacles in providing client with maximum assistance. These obstacles are described more specifically along with the problem areas in Charts I-IV.

(a) the unavailability of background information on many clients;
(b) the absence of coordination among the agencies serving the project;
(c) the confusion of other professionals about the role of the ILP social workers in the project;
(d) the social workers relationship with the counselors of the Division of Vocational Rehabilitation--problems that developed because of the general lack of knowledge of the extent of the role of these counselors.

General Factors Related to Success and Failure

Clients who were more severely disabled and those who had been disabled before they were ten-years old were far more

successful than their counterparts. Female clients who were wheelchair-bound were more successful than the ambulatory females. However, this did not hold true for the male population.

Although many clients entered the program with a high level of psychopathology, or "personality disorganization," this was not related to failure in the program.

One hypothesis focused on the clients' need expectations and the degree to which these needs were met. In particular, it was the hypothesis that finding work was an important factor in determining the client's successful adaptation to community living. This hypothesis was particularly directed to the male clients who were expected to fulfill a culturally prescribed role.

The results indicated that male clients who were working were significantly more successful than non-working male clients. This was not true however for the female clients. When a measure of the client's need for achievement was introduced, there was a significant difference between the working and the non-working clients. That is, clients who had a high need for achievement and who were working were significantly more successful than those who had a high need for achievement and were not working.

Wheelchair-bound clients were less affected in their successful adjustment when not working than ambulatory non-working clients.

Non-working females with at least a high school

education were significantly more successful than their counterparts without a high school education. (The reverse was true, however, for the non-working males.) The explanation for this result was based on the theory that the uneducated female suffers from greater role interference (namely, that of homemakers, which requires extensive physical capacities and coordination) than the educated female, who can fall back upon non-physical, intellectual activities, and who has probably developed a greater repertoire of time-filling skills.

The Effects of Social Work Intervention

The ILP was unique both in the demands made upon the social worker and in the opportunity it provided to combine a high degree of environmental manipulation, with direct counseling and intervention with others on behalf of the client. The role of the social worker in the ILP is similar to the role now being suggested as a prototype of the social worker needed in the future, namely, one which will combine environmental manipulation, providing direct services to the clients, and expediting community services for the clients.

The placement of the clients could not have been accomplished without the work of the social workers. Unfortunately the project was not set up to allow for an evaluation of the effectiveness of this type of social work intervention. It was, therefore, difficult to determine the effectiveness of the varied approaches used by the social workers in aiding the client's adaptation to community life.

An attempt was made to answer a number of questions, albeit in a limited way. The results listed below provide some perspective with which to view the nature of the problem areas and the types of assistance needed.

Comparison group. A comparison group of Department of Welfare clients was available to provide for an evaluation of the intensive nature of the social work performed by the ILP social workers. Although, after careful examination, not all in this group were found comparable to the ILP group, there was no major difference in the success of the two groups when utilizing the criteria of success as defined in this program. It was found, however, that many more of the project group had found employment.

Contrast population. A large number of disabled adults who had been referred to this agency, but who had not been placed were followed up. Only approximately one-third of the group replied to questionnaires. On the basis of evidence that many of these referrals had moved, it could be concluded that a high proportion of them had been institutionalized. Additional information obtained from those who responded indicated that many were living in unsuitable environments and needed the type of assistance and intervention that was provided by the ILP social workers to the clients in the project. Although many of these disabled adults had somehow managed to sustain themselves in the community, it would appear that many would eventually undergo psychological deterioration.

Social work contacts in counseling. In the limited analysis of the effects of the social work contact and counseling procedure, there did not appear to be any major differences in the success of those clients who received intensive intervention or depth-counseling. It was found that the social workers adapted their procedures according to the severity of the client's disability.

Individual social workers showed differential success rates. An analysis of their "working styles" indicated great variability, however, no specific social work approach that by itself would lead to client success could be isolated. The social workers who were successful were found to be different in their interpersonal perception.

Location. The geographic location of the client (that is, suburban versus urban) did not appear to play a major role

in affecting the success of the client. Wheelchair clients did not appear to be more limited in mobility in the suburban settings.

Foster family components. The income of the foster family was not related to the client's success. However, where the working male in the family was in a professional or skilled occupation, non-working male clients appeared to be highly unsuccessful. A possible explanation for this result was that the presence of a working male in the home may by contrast have given the client an unfavorable self-image.

In an investigation of a comparison of the style of life of the foster family and the disabled client, it was found that this was an important factor only for the non-working female population. In view of the amount of time that the non-working female client would spend in the home with the foster mother, it was suggested that the sharing of similar views and interests (reading the same newspaper, watching the same TV programs), would provide for a congenial and mutually satisfactory relationship.

Although, prior experience in work with the disabled did not appear to be related to the success or failure of the clients, it was found that for one group--the non-working male client, it was advantageous to have a foster mother who had had previous experience as a professional in a hospital or had boarders who had been handicapped.

Clients' Progress in Other Spheres

Clients who were not working and were eventually unsuccessful in the program felt themselves to be in a relatively poor state of health as compared to successful non-working clients. No relationship was found between an objective rating of the client's health and the client's subjective rating of his health. Clients who were successful were also found to have a high level of interpersonal relations, both qualitatively and quantitatively. This finding was especially clear among the female non-working population.

Factors Related to Environmental Changes

Among the successful clients, there were two identifiable groups who appeared to make the largest number of environmental changes. These included the female clients who found work and the cerebral palsied clients. Analysis of this data suggested that the CP clients require more trial environments than the other successful clients.

III. CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS

From the results of such a broadscale study there are naturally a great many conclusions. However, it can be seen that these, with their implications for the rehabilitation field, cluster around nine major areas of concern which will be described in this chapter together with the recommendations.

Procedures for Moving the Disabled into Suitable Environments

An analysis of the policy of the administrations of the various hospitals for the handicapped indicates that there may be some conflict in policy areas which interfere with the increased movement of potential clients into the community.

Those administrations whose policy encourages the discharge of the handicapped person not in need of hospital medical attention are the ones which provide this agency with the majority of its referrals. Those hospitals which are not equipped for the permanent care of the orthopedically handicapped show a greater tendency to favor the release of the

handicapped from institutional life. The other institutions, some of which have a structure that allows for the long-term confinement of the handicapped and operate under a system which rewards this policy, appear reluctant to make provisions for the necessary changes that would encourage the handicapped to search for a more adequate living arrangement.

The disabled client generally has a negative view about being institutionalized. However, this does not necessarily mean that he is ready to risk living in the community, assuming that he is even aware that there is a program that will enable him to do so.

It has been found that there are many disabled adults who are quite willing to take the risk but who are not sufficiently informed about the program, and who have a number of reservations about their chances for success in adapting to community life. This was particularly true of the more severely disabled, who felt there were too many procedural obstacles in getting released, and felt an "unexpressed" fear of family rejection if their families were still living.

One group that was served in the Project lived in "unsuitable environments," and on the basis of the analysis, it appears that most of them came from dingy hotel rooms or were living with parents who were mentally or physically incapacitated. From information obtained by the social workers in their interviews with the disabled clients and their families, it is only too apparent that there must be many physically disabled young adults who are living in the community in

environments that will probably lead to personality disintegration, vocationally or in interpersonal relations. Their lives are generally barren as they maintain themselves only at bare subsistence level.

Recommendations.

1. Hospitals with populations including orthopedically disabled adults, particularly those with young adults, should adopt a policy which would encourage the movement of these adults into the community. Each institution should establish a set of procedures which would facilitate this movement and outline the roles of the various staff members, particularly that of the medical social worker.

   The medical social worker who plays a major role in preparing the client for community living and in arranging for his discharge should meet periodically with the social workers, "central counselors" and vocational counselors to discuss areas of mutual concern and to open informal channels of communication. The roles of the social workers and counselors should be clearly outlined to avoid conflict regarding responsibility and jurisdiction. There should be careful planning to allow for the gradual shift of responsibility from hospital to community personnel.

2. In view of the additional work, medical case aides should be assigned to the medical social worker who could then concentrate on the discharge plans.

3. In order to allay feelings of anxiety on the part of the potential clients regarding community living, a program could be offered allowing them to "visit" families without the obligation to move into the community on a full-time basis. These clients should have an opportunity to evaluate the positive features and challenges community living may hold for them.

   The program should be focused on the "Independent Living" aspects and de-emphasize the "foster home" approach. A number of clients who are in institutions have parents who visit them but can not keep

them at home. The patients indicated they had no need to find "foster" parents since they had their own. Thus, the idea of moving in with "foster parents" touched on the client's latent feeling of rejection by his own family. A move to a foster family would indicate a complete rejection, since it would appear that another family could and would take him but that his own family would not.

Clients who have been successful in the program at the outset should visit institutions and talk to potential clients. The patients in the hospitals could then observe "examples of successful living" in the community and could question these clients closely on their experiences. It is more than likely that the rapport would be better between the successful and potential clients than between the social workers and potential clients.

4. Municipal agencies that might come into contact with disabled adults or their families living in unsuitable environments should be made aware of the possibility of moving these adults into other settings.

   A "central referral" agency should be established through which this placement can be made. This agency could help coordinate personnel working on a local basis and provide guidance for agencies which might serve this group.

Foster Homes for the Disabled

The conclusions indicate that foster home living is possible and feasible, particularly for the more severely disabled. Although, it was found that about 40 per cent of the clients were unable to be sustained in foster homes (or for that matter, in any positive environment in the community), it was not the foster home or the family that interfered with the client's adaptation to community living. Rather, there were other features of the environment, particularly the client's need to work, that were the basis of many of the clients'

failures.

Recommendation. In view of the low cost of foster home living as compared to other types of care, and the availability of many homes, it is recommended that this type of "living residence" be made available to many other disabled persons. (Note: This group did not include mentally retarded adults and, therefore, "foster homes" for this group cannot be recommended on the basis of these results.)

Other Types of Living Environment

As noted earlier, the concept of "foster home living" may not be the most fruitful approach for all disabled clients. Not only is the problem of admission of rejection by one's own family an obstacle for the disabled who have a family, but there are a number of alternatives that might prove fruitful. The many problems that arise when strangers live together and the great amount of service by social workers that is required to bring about harmony, suggest other types of living arrangements be investigated. Furthermore, the clients have many different types of disabilities and, for some specific handicapping conditions, the alternate arrangements may be superior.

Recommendations.

1. Co-operative residences. A number of disabled individuals might be able to live in a cooperative dwelling, provided that the aggregate of various abilities in the group would give each the type of assistance he needed. This type of arrangement might allow a greater degree of independence and provide more freedom for each of the clients. If the clients were young, some convenient "house-mother" arrangement with a nearby neighbor might be made. This type of living arrangement would be most suitable for disabled persons who have mobility and show a fair degree of stability and maturity.

Clients who are more severely disabled might live in a residence near an institution for the disabled where aides or nurses living nearby could provide some assistance at various times during the day. These clients would have the option of participating in some of the leisure-time activities of those in the institution, but could choose a program and regimen of their own.

2. Intermediate residence. An analysis of the case records and personality tests in the project indicates that many of the clients suffer from severe personality disorganization. In some cases, the client can be characterized as having schizoid or psychopathic tendencies, and in a number of other cases, the client has had a history of alcoholism or drug addiction. Lester Gelb recently noted that:

> "The physically disabled patient responds to his total environment and uses himself in a manner consistent with his personality. In the case of personality disturbance, the physical disability may be used either to express or to shield such a disturbance."[2]

This psychiatrist found that at the Institute for the Crippled and Disabled (in New York) a number of patients manifested personality disorders or neurotic reactions such as pathological dependency, schizoid personalities, and paranoid reactions, but that these disorders were more or less unrecognized.

Another researcher, in a Kansas City study of rehabilitation, remarked that:

> "The importance of the psychological aspects of chronic illness and disability cannot be over-emphasized in view of the widespread prevalence of intellectual and emotional characteristics which can serve as deterrents to rehabilitation success. Eighty-three percent of the study patients were thus handicapped beyond the actual limitations resulting from physical disability. Although it was true that a fairly large number of these had only minor psychological interferences requiring no special services, the fact remains that forty-eight percent, almost half, did have psychological

> problems serious enough to indicate some kind of special treatment or service if the rehabilitation goals were to be attained."[3]

Thus, many of the disabled suffer from severe personality disturbances exacerbated by their disability. Although the results indicate that clients who could be categorized as suffering from "severe personality disorganization" can make a suitable adjustment in community living, there is apparently a need for some intermediate placement in a foster home or in another type of independent living environment. These disabled adults who have been institutionalized for many years (some in hospitals for the mentally ill), or who have lived in "negative" environments, need some intense "milieu therapy" treatment before they can adjust to community life. Their personality disorganization is generally so great that they cannot accommodate themselves to community life. The type of treatment they would receive would have to be experimental and it would be necessary to investigate various approaches in a "structured environment" to allow them to make a reasonable transition from their previous pattern of living to a new one in a different setting.

An agency-operated "half-way house" might be one solution. This "house" could be staffed by "house" parents, by trained social workers and by aides who are also disabled but have reached a stage where they have sufficient insight and understanding to assist in providing a "therapeutic milieu."

Another solution could be a specialized temporary foster home. It has been the observation of the social workers in the project that certain foster mothers appeared to be most successful with clients who showed a particular personality pattern, such as withdrawal or depression. It might be possible to assign clients temporarily to those foster homes where the foster mothers seem to be well equipped to begin the alteration of these patterns of behavior.

Training in Social Skills

Disabled adults who have been handicapped most of their lives have not had sufficient opportunity to learn social skills.

Those who have been disabled later in life require an opportunity to relearn them. Some of the clients who have led a life which has been circumscribed by a limited environment, and who have lived by a set series of institutional rules, have had to learn or relearn a new set of skills and rules for community living. When control over his environment is limited, a person tends to follow a very specific, mannered way of doing even the most minute things, for he finds emotional security in such a routine.

As mentioned previously, the effects of total institutional living do not allow the client to develop a pattern of life common to community living. A break in the regular patterns or habits for those clients who have been institutionalized is seen as threatening. It is obvious that for a number of clients it was necessary to relearn "boundary" concepts and to relearn the method of interacting both with individuals and the physical community around them.

Recommendations. Clients who are to be placed in a foster home or similar setting should be provided with training in social skills. Where feasible, this training should begin in the institution. Many of the clients could also receive this training in existing centers and they should begin their training prior to or immediately upon being placed in their new environments. Those disabled adults who are placed in a "half-way" house could also receive this training in social skills as part of the overall program.

Central Record File or Data Bank

It was early established in the project that there was great difficulty in gathering background information about the clients, despite their multiple contacts with various agencies.

This situation was a reflection of a serious problem, namely the absence of coordination among the great variety of specialized agencies serving the disabled. The problem of compiling information necessary to enable the social worker to be of maximum assistance to the client was time-consuming and frequently required duplication of tests and interviews. Although the clients had come to the attention of many different agencies and counselors, the information that had been amassed about the client was unobtainable. It can be assumed that the information that is obtained is not organized in a format that would facilitate efficient retrieval.

Efficient record keeping, standardization of information and establishment of a system that would allow for easy and quick retrieval are apparently not viewed as important features in the services provided by many of the social welfare agencies. Just as individual social workers dislike standardization of any kind, so the agencies, apparently, do not have any great liking for uniformity and classification of material.

In attempting to assist the physically handicapped client it was, of course, necessary to collect some background medical information about the client. Medical prognoses and projections of the medical needs of the clients were requested from the "helping" institutions. At the outset, a simplified medical form was sent to the institution (with the request that it be completed prior to the client's discharge from the hospital). Unfortunately, it was not possible to obtain the information requested on the form submitted, and it was

necessary to depend on the medical abstracts furnished by the various institutions.

In order for the social worker to provide adequate counseling for the physically handicapped client, it is helpful to have information about the client's personality as obtained from various psychological tests. Although there have been few tests standardized on the physically handicapped, there are a number of skilled clinicians who can provide information about the clients which would assist the social worker in an analysis of the client's personality. This information was also very difficult to obtain.

In counseling, it is, of course, a major advantage to have information about the client's childhood and family background in order to understand the personality dynamics involved. It has been extremely difficult to obtain this information about many of the clients from the various agencies that have compiled such information. A considerable amount of counseling time had to be spent on obtaining information about the client's childhood and family.

Recommendation. There should be a central record file or "data bank" which would contain general background information about the client and give specifics about such tests that the client may have taken at any time during his connection with a hospital or any other institution. Inasmuch as the client does come into contact with many different agencies, it would be useful to have this information readily available. The testing area which has come under our particular scrutiny because of its importance in counseling the handicapped client has been that of intelligence capabilities. Records of intelligence tests taken by the client in an institution were received. In order to obtain additional information, however, the agency had its own clinician (who was skilled in working with handicapped clients) give the clients a series of tests,

including an additional intelligence test. In a number of cases, it was found that there was a great discrepancy between the intelligence score assigned to the client in the previous tests and the one that the agency clinician had assigned to this client. In view of the importance of the level of intelligence to counseling and rehabilitation and in assisting the client to adjust in the community, this is an area which should receive further scrutiny. It would be a good idea to develop a system whereby clients are tested by more than one clinician, in order to make certain that the client is given the most accurate score possible.

Although the general idea might require some modification, it is most important that information that is vital to rehabilitation be stored in a form that would make it usable by others. The amount of wasted time and effort this could eliminate, plus the exceptional advantages this would have for research on the handicapped, would certainly make the cost worthwhile.

The Importance of Work

The successful adjustment of the client was not solely or even mainly a function of an appropriate foster home placement or of social work intervention but was strongly affected by other environmental factors. For males, the opportunity to work appeared to be one of the crucial features in determining the degree of personal stability which effected their adjustment in the community.

Loneliness, boredom and the lack of an opportunity to fulfill a role that provides the individual with a feeling of social and personal worth led many of our unsuccessful clients to feelings of low self-esteem and resulted in personality disorganization.

One of the central factors that appears to have interfered in the community adjustment of the disabled adult males who had a high need achievement was the inability to find work

or to hold a job. This study illustrates that the goal of providing employment for the disabled is far from being reached, particularly for those with severe impairments whose need for work is strong, and for whom work apparently serves as a central life goal.[4]

Expectations and vocational counseling of the disabled. A major question that developed concerned the raising of expectations for the disabled that cannot be fulfilled because of the realities that currently exist in the society in which the disabled person functions.[5] Although the results are far from definitive, they do point to the conclusion that perhaps many of the disabled clients had their hopes raised with regard to employment and changes in their pattern of living. As we have noted in the study, the type of change anticipated was probably related to past experiences and the "need-structure" of the individual. However, a serious question is raised as to the degree to which the disabled client should attempt to realize vocational and other aspirations, when we feel quite certain that there will not be a satisfactory end result. In many cases, we cannot know what the possibilities for the client are prior to investigating various opportunities. However, it would appear that it is best not to raise the client's hopes too much when past experience indicates that the possibilities for success are not good. This is not to say that we should not work towards altering the structures that prevent the client from realizing his potential; however, it is the responsibility of the worker to be aware of the reality of the situation when counseling the client.

Various types of employment programs for the disabled have been examined in some detail recently, yet there does not appear to be any concensus as to the direction that would provide for the needs of the type of disabled population represented in this study. It would seem appropriate at this time when the "poverty" programs are examining the various employment opportunities for the disadvantaged, to make a more thorough examination of new possibilities of employment for the disabled, and perhaps set up a quota for the employment of the severely disabled in various industries. An examination indicates that many of the disabled are under-employed and although there is no wish to make any value judgments with respect to the use of "workshops," it appears that the concept of work and the meaning of various types of employment schemes for the disabled must force rethinking on the alternatives to this setting for employing the "unemployables."

One approach that is currently under examination in

providing for the employment needs of the "poverty youths," that of the "New Careers," deserves some consideration as a way of meeting the needs of the disabled. Basically, the objectives of this approach are to create jobs in areas where there is a need for personnel and to train the unskilled for these jobs. In many cases the jobs can even be structured and organized so as to provide employment for adults with special handicaps. Disabled adults could work in many roles in the spheres of health, education and welfare as aides and assistants. These developing occupations provide many opportunities for proliferating the roles of those now working in these areas and might offer possibilities of meaningful work which would enhance the self-esteem and self-realization of disabled male adults.[6]

Recommendations.

1. A special unit should be established to investigate the possibilities for employment of disabled adults in the areas of health, education, and welfare and to determine the types of skills and training needed for these "New Careers."[7]

2. The unit should work with various public and private agencies to determine whether some of the existing positions could be subdivided to provide for the employment of the disabled.

3. Special programs providing training for these positions should be established and be made available to disabled male adults.

Community Organization for the Disabled

The results all point to the conclusion that the most effective approach to maintaining the physically disabled in the community and assisting them in advancing in social and occupational functioning requires the close cooperation of all of the agencies serving the disabled.[8]

The range of services required by the disabled adult (see Charts I-IV, pages 155-163), and the multiplicity of agencies that exist to provide these services, and the variety of professionals employed to work with the disabled illustrate

the fragmentation of services provided. The crazyquilt of organizations and staffs, it was found in this study, multiplies the problems confronting the clients and causes confusion and chaos for many of the personnel employed by the agencies. A reorganization of the pattern of services for the disabled is admittedly a difficult and complex task. With the current emphasis on community (or neighborhood) services in the poverty programs, it would be wise to consider the reorganization of the services being provided to the disabled.

The pattern of living of the disabled adult in the community has been followed for a number of years through this study, and a number of suggestions are offered which it is felt could be adapted to the existing organizational structure which would require the smallest number of modifications in the current pattern of services.

Co-ordination of Services: Personnel

The need for personnel who can provide the disabled adult with guidance and assistance in a host of areas is clearly evident. What is also obvious is that there is a high degree of overlapping of function among the many professionals serving the disabled.[9] This vagueness of professional role and the absence of co-ordination prevent the clients from receiving maximum service. An analysis of services indicates the possibility that non-professional staff could fill some of the client's needs.

The social workers in the project were playing different roles simultaneously. They were expected to provide

the counseling that would enable the client to adjust satisfactorily in the community and in his immediate environment. In this sense it was a role compatible with the general role of a caseworker. A major distinction, however, was in the population that would be served via this role, namely, a group of physically disabled adults whose problems were not necessarily related to the personality difficulties that required modification, or further insight on the part of the client.

The additional role expected of the social worker was that of serving as an intervening agent with other agencies and persons from whom the client might be receiving services, and finding and deciding on an adequate residence or community for the client. The social worker was also to work with the foster family at the outset of the placement venture or when problems arose.

Although the general nature of the work was obvious, the many different requirements of the roles could not be envisioned at the outset. It may seem that the social workers in the project were attempting to work in too many areas on behalf of the client, but comments by the clients indicate that a role was being performed that filled in important elements missing from other services that were given to them.

The social workers were available at almost all hours of the day (and sometimes during the evening). They served as intervening agents, frequently expediting services by interpreting the client's needs more adequately to the appropriate agency personnel. The client knew there was someone he could turn to who knew him well and could discuss any of his wide range of needs.

The results do not permit any conclusions regarding the overall effectiveness of the social workers' techniques. However, apart from the statistical data, it is apparent that some type of counselor was necessary if the clients were to make adjustment to community living. Once the adult is in a home, the study indicates that many of them can sustain themselves with only minimal assistance.

The disabled clients in this project were served by many institutions and agencies, including the Department of Welfare and the Division of Vocational Rehabilitation. The problem confronting the client was that of having to work with a great variety of personnel. In order to receive special welfare benefits, the client had to communicate at times not only with the social investigator but also with a special department. If the client were able to work, he had to go to the Division of Vocational Rehabilitation and meet with the counselor who would decide on the type of training he was to receive or a position for which he might be eligible. Any medical

assistance he needed required contact with a hospital or perhaps a rehabilitation agency. And should the client want recreation, there would be another agency to see about the facilities and groups that would meet his needs in this area. There were, of course, many areas, particularly in the field of education, in which no services were available.

The major misunderstandings in inter-agency relations were with the Department of Welfare and the Division of Vocational Rehabilitation. There is no attempt here to cast blame on any agency inasmuch as the nature of the problem was in essence one that could not be resolved under existing circumstances, even by the most dedicated administrators.

In most cases, our clients were receiving assistance from the Department of Welfare. The communication with this agency was a difficult one because of the problems that are basically inherent in the nature of this agency. In many cases, it took considerable time to have the home of the foster family approved so that the client could move in. The busy schedule of the Welfare Department workers often meant that our clients had to wait a considerable period of time to obtain some necessary items. The clients themselves were usually not sufficiently aggressive to make demands for things which they actually had a right to, and took no action when they did not receive the services to which they were entitled. It was necessary for the social workers in this agency to contact repeatedly the Welfare Department worker (who was not too familiar with the situation) to expedite some of the services. It was also quite obvious that because of the heavy load carried by the Department of Welfare workers, they could not keep track of or locate information about the client so that the particular problem could be dealt with quickly.

The results of this study indicate the central role that work plays in effecting the adjustment of the disabled adult. Unfortunately, because of lack of understanding of the role of the counselors at the Division of Vocational Rehabilitation, needless friction developed. It was apparent in the analysis of the problems between the counselors of DVR and this project that neither quite understood completely what the other was doing for the client. Part of this was the result of the somewhat unique and central role played by the social workers in the project and of the importance of obtaining work in order to protect the placement. Many of the clients could not work in any of the positions DVR could obtain. Also, there were problems that confronted the DVR counselors that were not understood by the social workers in the project.

Allocation of Personnel and Type of Services

One of the key questions raised in this program based

on the intensive services provided by social work and other personnel focused on the type of service to be given to clients with varying levels of severity of disability and potential. Clients ranged from those who were dull normal to those who were extremely bright and intelligent with excellent potential for work and advancement in this and other areas.

The view that appears most widely accepted is that the disabled individual with the most severe disabilities and problems should receive the intensive services of the most qualified personnel because they need more services. Unfortunately, the question as to the degree of possible advancement some of these clients can make is not frequently discussed. On the basis of the results of this study, it is suggested that it is the individual with the highest possible potential who needs the services of the most qualified personnel because he can make the greatest strides and the personnel working with him will frequently find the results most gratifying. Disabled clients who have lesser potential because of severity of disability and limited intelligence should receive the most extensive type of services but these can frequently be provided by personnel who have less training if there is good supervision. Related to this question are the important problems of how to allocate manpower resources and to decide on the type of services, both with regard to quality and to the time they should expend on the various types of disabled clients.

Although the effects on personnel (in this case, social

workers) of working with clients whose potential appears very limited cannot be discussed here in detail, it does appear that enthusiasm and morale are related to the number of clients a worker has who have good potential and where progress can more readily be seen.

Recommendations.

1. The disabled person is in need of a "community agent for the disabled" who can co-ordinate the many necessary services, and a specialist who can provide the necessary "expertise" in guiding and assisting in areas of work and education (vocational rehabilitation counselor). These two should work as a "team," with the "community agent for the disabled" being located in, or at least most familiar with the district where the client lives.[10]

2. A "task analysis" of the services provided by the social workers in this study (who in effect worked as community agents for the disabled) clearly indicates that there are many areas in which a trained non-professional could perform the same tasks. This role, as illustrated in the "role analysis," is acting as an "intervening" or "expediting" agent by arranging for the client to receive services or items to which he is entitled but, because of the complexity of the welfare system, he is unable to obtain.

The type of non-professional who could perform these tasks is similar to the "expediting" agent who has been suggested for use with the "poor." Actually, many of the clients fall into this socio-economic population and it is possible that they could receive the services of this "expediter," placed in an agency located in many areas throughout the city. These personnel could be located in many different institutions ranging from community mental health centers to other types of community centers and agencies.

Personnel located in the neighborhood of the client are more likely to be familiar with the facilities of the area and thereby would be of greater assistance in aiding in his integration.

Further, the major problem of transportation of the client to a meeting place would be lessened by the district location of the central counselor.[11]

3. Supervision of the non-professional "community agents for the disabled" should be given by professional social workers and vocational or rehabilitation counselors who have experience in working with the disabled. This supervisory group could be employed by a central agency in the community. Another possibility is that supervisory responsibility be accepted by a University School of Social Work which would also incorporate the training of the non- or sub-professional workers.

4. Another alternative is the establishment of neighborhood facilities for the Department of Vocational Rehabilitation. Although this would require some restructuring of the roles and tasks as currently practiced by the DVR counselors,[12] it is possible that this could be an important step in providing for the more effective vocational rehabilitation of disabled persons. Local DVR centers could also employ sub-professionals who would perform some of the more routine tasks and leave the DVR counselor free to perform those that are more in line with his professional qualifications.

Final Conclusions

One of the basic problems that pervades all of the results in this study and that became readily apparent to the researchers was the absence of a coordinated patter of services to provide for the diverse needs of the large numbers of physically disabled in this urban complex. The lack of adequate housing, appropriate recreation and educational facilities, meaningful employment and trained personnel to aid the disabled in obtaining the services from the maze of agencies that exist in this urban area was so great that it must be concluded there exist large numbers of disabled adults in this

city who are living lives of marginal existence. Mental deterioration has already taken its toll and will probably continue to do so on a more intensive basis. Although many of the problems that confront the disabled are problems that are central to much of city life, the disabled are more affected by the decay in urban existence because of their great dependency upon others.

There did not appear to be any major gaps in the medical needs of the clients, and it was evident that the client's physical state was in better shape than his mental state.

On the individual level, it was found that the disabled adults varied greatly in their needs and their levels of aspirations. Similar experiences had different effects on clients, and the stresses of the environment resulted in severe personality disorganization in some of them. The inability to find work led to states of severe anxiety, depression and hostility, particularly on the part of male clients who had a high need for achievement. Although many suggestions have been made with respect to aiding the client in finding alternate means of occupying his time, work is still viewed as central to the role of the male.

Innovations, new facilities and breakthroughs in medicine are providing new hopes for the physically disabled. Methods of increasing the disabled adult's self-esteem and feelings of optimism for his future and of finding a place for him in a community are lagging far behind. Perhaps the great experimentation that, it is hoped, will bring about the

rebuilding of the cities will at the same time provide some beneficial changes for the physically disabled adult.

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REFERENCES

[1]Since the inception of the study, a number of changes have been introduced in the practices of the movement of rehabilitation clients from hospitals into the community. See: F. Racker, E. Delagi, and A. Abramson, "The Therapeutic Community: An Approach to Medical Rehabilitation," Archives of Physical Medicine and Rehabilitation, Vol. 44 (May, 1963), pp. 257-261; A. Abramson, B. Kutner, P. Rosenberg, R. Bergen, and H. Weiner, "A Therapeutic Community in a General Hospital: Adaptation to a Rehabilitation Service," Journal of Chronic Diseases, Vol. 16 (February, 1963), pp. 179-186; also B. Kutner, "Modes of Treating the Chronically Ill," The Gerontologist, Vol. 4, No. 2, Part II (June, 1964), pp. 44-48.

A project just started, "Mobilization for Maturity," an extension of the therapeutic community program, focuses on the organization of services for disabled clients after they leave the hospital. The Columbia University School of Social Work has also recently embarked on a large-scale program with Bird S. Coler Hospital emphasizing the hospital-community continuum, and has assumed control over the rehabilitation of the client both in the hospital and in the community.

[2]L.A. Gelb, "Personality Disorganization Camouflaged by Physical Handicaps," Mental Hygiene, Vol. 45 (April, 1961), pp. 207-215.

[3]Louis E. Masterman, Psychological Aspects of Rehabilitation: Follow-up Study (Kansas City, Missouri: Kansas City Rehabilitation Experiment, Community Studies, Inc., May, 1961).

[4]Thomas Edwin Rickard, Indices of Employer Prejudice, An Analysis of Psychological Aspects of Prejudice Toward the Disabled Worker (Champaign, Illinois: University of Illinois, Division of Rehabilitation-Education Services Rehabilitation Center, 1962).

[5]Another point of view as to possible substitutes for work for disabled males was best expressed in: David J. Kallen, Disability and the Community, Health and Welfare Council of the Baltimore Area, Inc. Paper read at the Region III meeting of the National Rehabilitation Association, Washington, D.C., July 17, 1961.

He noted that the results of his study indicated,

> "the great importance of providing the disabled person with a series of experiences that will serve to increase his sense of his own competence.

> There are some indications that well planned leisure time activities can provide these experiences, serving the same function for the more seriously disabled that successful work experience does for the less disabled."

Although this view has been expressed by many others, there is little in the way of research which indicates that leisure time activities are an acceptable substitute for work for disabled male adults.

[6]An intensive and detailed analysis of the relationships between needs, satisfaction, and work was done at the University of Minnesota and has been reported upon in a series of monographs. See in particular: "Seven Years of Research on Work Adjustment," Minnesota Studies in Vocational Rehabilitation: XX, University of Minnesota, Bulletin 43 (February, 1966).

[7]The types of new jobs that can be created categorized under the concept of new careers is discussed in: Arthur Pearl, and Frank Reissman, New Careers for the Poor (New York: The Free Press, 1965); and Fishman, et al., Training for New Careers, published by the President's Commission on Juvenile Delinquency and Youth Crime, June, 1965.

Also see: W. Scott Allan, "Breaking the Barriers to Effective Rehabilitation in Insurance Cases," Rehabilitation Literature, Vol. 23, No. 4 (April, 1962), p. 98.

> "The real results of this in future years will be that work opportunities for most people will lie in totally different areas than they do today. Principal emphasis will be upon the creative and graphic arts, upon professional careers, upon specialized government jobs of various kinds, upon jobs that deal more with the problems of people and services to people rather than the production of goods. It does not require great imagination to see what the effect of these changes is going to be upon the employment of handicapped persons. On the one hand, it may provide much greater opportunity, if skills can be developed and training can be provided for many kinds of work opportunities that make no essential physical demands and, therefore, are much better suited to handicapped individuals. On the other hand, opportunities to place handicapped workers who are in the unskilled or semi-skilled categories are going to diminish sharply and there is going to be a great deal more need for complete retraining if we are

> going to have any chance of providing employment opportunities for such workers. In the light of present predictions, we ought to be already carrying on research and developing procedures and training programs in anticipation of future changing work opportunities and business needs."

Various recommendations, both old and new, for programs for the disabled, have been discussed in numerous publications. For a brief discussion of more than a decade ago, yet still valid and immediate, see Roger G. Barker et al., Adjustment to Physical Handicap and Illness: A Survey of the Social Psychology of Physique and Disability (New York: Social Science Research Council, 1953), Chapter VIII.

For a recent analysis of the role of the workshop, see Bertram J. Black, "The Workshop in a Changing World: The Three Faces of the Sheltered Workshop," Rehabilitation Literature, Vol. 26 (August, 1965), pp. 230; and William Gellman and Simon B. Friedman, "The Workshop as a Clinical Rehabilitation Tool," Rehabilitation Literature, Vol. 26 (February, 1965), p. 34.

A unique approach is described in: E.C. Cline, "Businessmen Teach Handicapped - Decatur Job Training Center," Rehabilitation Record, 3 (July-August, 1962), pp. 6-8. Businessmen were contacted to determine the type of skilled workers they needed and then the workers were trained to meet the need. In three years, the Decatur Job Training Center has trained 178 clients of Division of Rehabilitation and 167 have been successfully placed.

[8]Simon Olshansky and Reuben J. Margolin, Ed.D., "Rehabilitation as a Dynamic Interaction of Systems," Journal of Rehabilitation (May-June, 1963).

Altro Health and Rehabilitation Agency was apparently able to work out a system of coordination and cooperation for its own program. The problem of establishing this framework on a larger scale in an urban area, integrating the functions of a number of agencies has not yet been attempted. See: Bertram J. Black and Harold M. Kase, "Interagency Cooperation in Rehabilitation and Mental Health," The Social Service Review, Vol. VII, No. 1 (March, 1963).

[9]George J. Goldin, "Rehabilitation Counseling Criteria," Rehabilitation Record, Vol. 5, No. 2 (September-October, 1964).

Goldin's description of the work of the rehabilitation counselor illustrates the role conflict that was involved in our study. He notes that: "That role of the rehabilitation counselor involves the coordination and synthesis of a number of activities by different professionals into a helping process

designated as rehabilitation. His ability to coordinate and motivate top performance by these professionals is as crucial in performance quality as is his ability to motivate the client."

George J. Goldin, "Some Rehabilitation Counselor Attitudes Toward Their Professional Role," Rehabilitation Literature, Vol. 27, No. 12 (1966), pp. 360-364.

Goldin notes that: "This study of rehabilitation counselors in the agency reflects a profession that is in a state of flux, struggling to define its role while its practitioners suffer from feelings of inadequacy relative to other professions that enjoy more clearly defined roles. In their quest for professional identity, counselors see the therapeutic orientation as a valuable device for working with their clients and enhancing their professional prestige. The high orientation of the vocational rehabilitation counselor to succeed in placement of clients is seen in his selection of cases for service offering the personal gratification of professional achievement."

[10]Some of these issues have been discussed recently as reported in: Martin Dishart, Vital Issues and Recommendations from the 1965 National Institutes for Rehabilitation Research (Washington, D.C.: National Rehabilitation Association, 1965), Chapter VI.

[11]Howard R. Kelman, Ph.D., Jonas N. Muller, M.D., and Milton Lowenthal, M.D., Continuous Care Study of Chronically Ill Patients (New York City Health Research Council Grant U-1149, July 1, 1961 to June 30, 1964).

The researchers noted: "Study was concerned with the reasons for the success and failure of these patients to thrive in the community following intensive hospital rehabilitation care."

Also, on page 142:

> "In this study little evidence was forthcoming of obvious gaps in needed rehabilitation services, critical to the maintenance of continued community residence. However, vital to the continued deliverance and receipt of these and of other health and social services, was the assumption of the 'coordinator' role by the patient or someone around him. The aggressive prodding and probing of aftercare resources and personnel was instrumental in overcoming frequent time lags, communication failures and other administrative and procedural barriers which patients and their families or caretakers encountered in obtaining needed services.

The 'coordinator' role was assumed less frequently by aftercare agency staff members."

[12]A recent discussion on the use of sub-professionals can be found in: M.R. Baker, "Approaches to a Differential Use of Staff," Social Casework, Vol. 47, No. 4 (1966), pp. 228-233.

Also see: Frank Reissman, "Strategies and Suggestions for Training Non-Professionals," An unpublished paper; and "The Neighborhood Service Center--An Innovation in Preventive Psychiatry," A paper delivered at the American Psychiatric Association Meeting, Atlantic City, New Jersey, May, 1966.

Frances A. Koestler (ed.), Manpower Utilization in Rehabilitation in New York City, New York City Regional Inter-departmental Rehabilitation Committee, September, 1966.

Robert Kelso, "To Utilize Non-Professionally Trained Women as Rehabilitation Aides to Serve Clients in Sparsely Settled Areas of Wyoming," Progress Report, Division of Vocational Rehabilitation, Wyoming, 1966.

The allocation of personnel was recently discussed by W.A. McCauley in an address before a meeting of the New York City Chapter of National Rehabilitation Association on June 17, 1966:

"There is some suggestion that intake become a segmentized practice with highly skilled interviewing personnel being responsible to forecast the spheres where definite problems can be anticipated in the client movement through the rehabilitation treatment process. Those cases in which the client seems to have a very fair comprehension of his problems, and has the capacity and strength to move toward their solution with a minimum amount of help, may be assigned to a lesser skilled person who would be majorly responsible for opening doors and aiding the client to use appropriate resources for services. Cases with more complicated problems, with lesser strengths and capacities, may be expected to be assigned to more skilled personnel carrying a relatively smaller caseload and being more responsible for utilizing the help of support personnel and supervising roles; thus, bringing a broader scope of services and more intensified practice that the client needs."

APPENDIX

PERSONALITY FACTORS CHANGE SCHEDULE (P.F.C.S.)

This schedule was given in successive waves in an attempt to measure changes in the behavior of clients as a result of changes in his personality. The P.F.C.S., therefore, can for purposes of analysis be viewed as an intermediate observation linking psychological factors with overt behavior. The schedule consists of twelve personality factors which the social worker has been instructed to use in order to rate his client across three dimensions of his everyday activities (work, interpersonal relations and recreation). In each case he is to indicate the intensity and the duration of the effects of each personality variable.

It was hoped that the results of the schedule would in effect yield a dynamic profile of the client's behavior as a result of personality disorganization. This, however, did not prove to be the case. The social workers found that they could not use the P.F.C.S. in a meaningful way. Despite the attempt of the research director to carefully define each of the factors involved, so that the workers had a common frame of reference, the social workers found it difficult, if not impossible, to differentiate between the factors or to understand correctly the terms (intensity and duration) involved. What did emerge was the fact that the schedule was used as a general indicator of the client's level of mental health. Due to the scoring system, values of the P.F.C.S. when added up ranged from 12-36. A high score indicated high personality disorganization.

It was further found that a high correlation existed between P.F.C.S. scores and behavioral indicators of personality disorganization such as length of stay in a hospital, breakdown, suicides, etc. The question which we now face is whether or not the P.F.C.S. was in effect giving us any new information--information which could not as readily be found by examining the client's behavior.

At the very least, however, we had now found a way to generate a continuous dependent variable to indicate the client's success or failure in the program. If, as aforementioned, high P.F.C.S. scores indicated a greater probability of failure in the program, these same scores could now be used as our indicator of success. The advantages of a continuous dependent variable for statistical research are well known.

The staff faced one more technical problem. The scoring on the P.F.C.S. (as well as on the other tests such as the A.R.S., to be included and discussed later) unfortunately was not uniform between social workers. Idiosyncratic differences

were noted in the range of a social workers scoring behavior. Independent checks revealed that these differences were not a result of the social workers having significantly different populations. Therefore, we devised a method for standardizing patients scores which is described in the technical note following.

TECHNICAL NOTE

In scoring and analyzing patients scores on the P.F.C.S., one of the problems encountered dealt with different methods of scoring by the various social workers. In order to hold constant this interference, the scores on the P.F.C.S. were standardized for each social worker. That is, the mean and standard deviation were computed for each social worker and individual scores were then translated into normal standard deviates. This enabled us to interpret P.F.C.S. scores uniformly.

We then divided our population into three categories. Since the P.F.C.S. values were now standardized, the probability of any individual score or group of scores could easily be found by referring to a table of normal probabilities. For purposes of analysis, we chose our three categories as follows:

1. The lower-quartile scores less than +.675 representing the healthiest group - fair degree of personality organization.

2. The middle 50 per cent or scores between +.675 and -.675. This group represents the group with moderate personality disorganization and is to be considered our median group.

3. The top-quartile or scores greater than +.675 represents the group with the highest degree of personality disorganization.

The social workers evaluated the behavior of the disabled client and indicated which of the personality factors that were listed as causing impairment to the client's functioning in the community was present in his makeup. There was no attempt to work with a specific personality theory, but rather to have the SW, on the basis of her knowledge of the situation, report the degree to which the particular behavioral or attitudinal factor was harmful to the client or

to others.

The behavioral areas listed could be classified under two general categories: "withdrawal" and "striking out." As detailed in the descriptions classifying the behavior of the client, the factors of anxiety, depression, dependency, fantasy, lack of self confidence, projection of blame and feelings of rejection all promote withdrawal tendencies. When the factor is classified as disabling, the client is frequently immobilized and turns his hostility and blame inward and, in extreme cases, this would result in isolation or suicide attempts. The term "hostility" was used to denote violent behavior with either physical or verbal abuse.

The heavy emphasis placed on the factors describing the general trait of "turning inward" and/or thus becoming totally immobilized was due to the general belief that this behavior is more characteristic of disabled persons than of others. One additional factor was included: "the realism of the client's goals." Although this factor is not evidenced from a particular form of behavior, we felt it would provide information about the relationship between the other factors as reflected by the client's attitude in this area.

PERSONALITY FACTORS

ANXIETY: involves debilitating states of constant apprehension, worry, or overconcern without the patient understanding just what it was he feared; or it could be attached to some specific object or possibility such as exaggerated fears of crowds, traffic, further disability, loss of status, etc. An extreme form of this condition would involve a constant and severe state of chronic and debilitating anxiety that it was virtually impossible for the patient to mobilize himself to constructive action.

DEPRESSION: could include agitated depression and reactive depression, as well as feelings of discouragement and pessimism for the future and/or for success in a new environment. Complaints of boredom and monotony in their current way of life and of feeling generally "down in the dumps." Seeks limited involvement in activities and relationships; may complain of fatique. Generally "listless" appearance.

DEPENDENCY: involves passive attitudes on the part of the patient towards his environment, a reluctance to put forth effort in his own behalf, and a tendency to rely on other people (such as allowing others to make all the decisions) to a degree beyond that which was actually necessitated by his disabilities. Thus, the patient who becomes satisfied with his meagre income from public welfare to the point that the effort required to become self-supporting was not worth the possible economic improvement--or the patient who is reluctant to give up his wheelchair or crutches rather than make the effort to learn to walk.

FANTASY: patients who spend an inordinate amount of time and effort in day dreaming about such things as miraculous recovery, their life situations prior to the time of onset of their disabilities and other situations which could serve as escape from realities of living productively with their disabilities.

GUILT: patients who feel censurable because of their disabilities or because they were unable to fulfill their expected life roles, or for any reason which tended to make them feel that their disabilities were a justifiable, though perhaps undesirable, punishment.

HOSTILITY: includes not only feelings of hostility directed toward the environment but also refers to overt manifestations of hostile attitudes through aggressive, "striking-out" behavior. Hostility might take the form of verbal abuse of those around the patient or is expressed by negativistic attitudes and refusal to cooperate.

HYPOCHONDRIASIS: overconcern about bodily health and functions; use also of non-existent disabilities to promote and maintain dependent status; constant complaints about the non-existent disabilities or frequent unnecessary trips to the doctor.

EMOTIONAL CONTROL: inadequate emotional control; very little intellectual control of their emotional life and as a result are inclined to laugh or cry disproportionately to the stimulus, or who were inclined to "lose their tempers" quickly, or who became irritated and upset with seemingly little provocation.

SELF-CONFIDENCE: an unrealistically low opinion on the part of the patient concerning his own abilities to the point where he was fearful of putting forth necessary efforts to improve himself lest he fail in his attempts.

PROJECTION OF BLAME: patients who, in order to excuse their inadequacies, were apt to place the responsibility for their lack of achievement upon circumstances or other people beyond their control rather than make any effort toward self-improvement.

REJECTION: patient feels that he is unwanted and undesirable because of his disability. Involves an oversensitivity to the attitudes and intentions of other people, and occasionally real feelings of persecution.

GOALS: unrealistically high goals; patient's aspiration levels high beyond reasonable expectation and tended to interfere with the acceptance of more realistic goals. The goals may have been treatment and recovery goals as well as education, vocational, or even social goals.

This form is the final modified version used in coding the P.F.C.S. The following factors are evaluated for each of the clients on the basis of how they affected the client in his relations with others (interpersonal relations).

Definitions

Disabling - The presence of this factor in the client's personality, or his attitude, affects his ability in the areas outlined to the degree that he withdraws from these activities or others withdraw from him.

Interfering - Factor is also present but although it interferes with a client's reasonable adjustment in the area outlined, the client does function if only to a limited degree. (Functioning in the community would be harmful to the client or to others.)

Non-Interfering - The factors listed do not play a role and so the client makes a reasonable adjustment in the area outlined.

Factor	Disabling	Interfering	Non-Interfering
ANXIETY	3	2	1
DEPRESSION	3	2	1
DEPENDENCY	3	2	1
FANTASY	3	2	1
GUILT	3	2	1
HOSTILITY	3	2	1
HYPOCHONDRIASIS	3	2	1
EMOTIONAL CONTROL	3	2	1
SELF-CONFIDENCE	3	2	1
PROJECTION OF BLAME	3	2	1
REJECTION	3	2	1
GOALS (Realistic)	3	2	1

INTERVAL HEALTH HISTORY

In order to periodically assess changes in our clients' subjective feelings about their health, the Interval Health History was used. This questionnaire consists of seven items, balanced for direction:

	Score
1. Would you say that in the past four months your health in general has been:	
( ) 1. Excellent or good	1
( ) 2. Fair	2
( ) 3. Poor or very poor	3
2. Were you worried about your health:	
( ) 1. All or most of the time	3
( ) 2. Only sometimes	2
( ) 3. Never	1
3. Have you had:	
( ) 1. More energy	1
( ) 2. About the same amount of energy	2
( ) 3. Or less energy	3
4. Has your appetite been	
( ) 1. Poor	3
( ) 2. Fair	2
( ) 3. Good or too good	1
5. Have you had any trouble in getting to sleep or staying asleep? Would you say:	
( ) 1. Often	3
( ) 2. Sometimes	2
( ) 3. Never	1
6. Most of the time have you been in	
( ) 1. High or good spirits	1
( ) 2. Fair spirits	2
( ) 3. Low or very low spirits	3
7. Have you had any colds, flu or fevers:	
( ) 1. Many	3
( ) 2. One or two	2
( ) 3. None	1

Answers to the seven questions were scored on three point scales, in which the low score of "1" was given to an answer indicating health, "2" for the neutral or middle position, and "3" for an answer indicating poor subjective health. Thus, items 1, 3 and 6 were scored as answered, while items 2, 4, 5 and 7 were scored in the reverse direction. A client's score could theoretically range from 7 to 21. The results reported here were based upon the individual client's answers to the questionnaire at approximately the time of his maximal adjustment to independent living within a range of 6 months to 2 years from original date of placement.

ADJECTIVE RATING SCALE (ARS)

NAME: _____ DATE:

S.W.: _____

1.	Ambitious	:	:	:	:	:	:	: Happy-go-lucky
2.	Many interests	:	:	:	:	:	:	: Specific interests
3.	Warm	:	:	:	:	:	:	: Cold
4.	Stubborn	:	:	:	:	:	:	: Easy-going
5.	Intellectual	:	:	:	:	:	:	: Practical
6.	Cooperative	:	:	:	:	:	:	: Competitive
7.	Nervous	:	:	:	:	:	:	: Calm
8.	Neat	:	:	:	:	:	:	: Careless
9.	Smooth	:	:	:	:	:	:	: Rough
10.	Questioning	:	:	:	:	:	:	: Accepting
11.	Simple	:	:	:	:	:	:	: Complex
12.	Submissive	:	:	:	:	:	:	: Aggressive
13.	Awkward	:	:	:	:	:	:	: Poised
14.	Introverted	:	:	:	:	:	:	: Extroverted
15.	Soft	:	:	:	:	:	:	: Hard
16.	Optimistic	:	:	:	:	:	:	: Pessimistic
17.	Skeptical	:	:	:	:	:	:	: Trusting
18.	Restless	:	:	:	:	:	:	: Placid
19.	Respectful	:	:	:	:	:	:	: Sarcastic
20.	Flexible	:	:	:	:	:	:	: Rigid
21.	Far	:	:	:	:	:	:	: Close
22.	Average	:	:	:	:	:	:	: Different
23.	Self-satisfied	:	:	:	:	:	:	: Concerned with others
24.	Flexible Morals	:	:	:	:	:	:	: High Morals
25.	Friendly	:	:	:	:	:	:	: Restrained
26.	Non-Conforming	:	:	:	:	:	:	: Conventional

NEED ACHIEVEMENT AND THE ARS

Our measure of need achievement was based on five sets of adjective pairs from the ARS (described earlier), on which the SWs rated their clients at the time of placement. These items were chosen on the basis of their reflection of the achievement motive:

	HIGH NEED			LOW NEED
Item #	Achievement (7, 6 or 5)	Neutral (4)	Achievement (3, 2 or 1)	
1	ambitious ___ ___ ___	___	___ ___ ___	happy-go-lucky
6	competitive ___ ___ ___	___	___ ___ ___	cooperative
10	questioning ___ ___ ___	___	___ ___ ___	accepting
12	aggressive ___ ___ ___	___	___ ___ ___	submissive
17	skeptical ___ ___ ___	___	___ ___ ___	trusting

Scores of 7, 6 or 5 were taken to represent the "high need achievement" side of each adjective polarity. Scores of 3, 2 or 1 represented "low need achievement." Mid-point scores of 4 were interpreted as neutral or equivocal. Clients scoring 7, 6 or 5 for at least 3 of the 5 adjective pairs were placed in the "high need achiever" category (HNA). Those scoring 1, 2 or 3 for at least 3 of the 5 adjective pairs were designated "low need achievers" (LNA). Omitting those on whom these ratings were not available and those receiving neutral or mixed ratings, we formed two extreme groups, comprising 31 HNA and 21 LNA clients.

As a reliability check, two raters filled out ARS forms for every client on the basis of their reading of the full case histories. Agreement with the SW approximated 75 per cent for the five adjective pairs used in the need achievement ratings and was significant for all adjectives.

VOCATIONAL INDEX

ARE YOU NOW WORKING:
21. 1- ( ) Yes
    2- ( ) No

HOW MANY HOUR A WEEK:
22. 1- ( ) Full time (35-40 hrs.)
    2- ( ) Part time (20-35 hrs.)
    3- ( ) Few hours (to 20 hrs.)
    4- ( ) Not working

HOW MUCH DO YOU GET PAID:
23. 1- ( ) $1.25 an hour or better
    2- ( ) $1 to $1.25
    3- ( ) .75 to $1.00
    4- ( ) Less than .75 an hour

IS YOUR WORK----FROM HERE:
24. 1- ( ) very far (more than 1 mile)
    2- ( ) not far (less than 1 mile)
    3- ( ) nearby (a few blocks)
    4- ( ) works at home
    5- ( ) not working

IF NOT WORKING, HAVE YOU OR SOMEONE ELSE LOOKED FOR A JOB FOR YOU:
25. 1- ( ) Yes
    2- ( ) No
    3- ( ) Not applicable; working

HAVE YOU HAD A JOB SINCE YOU'VE BEEN HERE:
26. 1- ( ) Yes
    2- ( ) No

REASONS FOR LEAVING:
27. 1- ( ) hasn't left job
    2- ( ) quite (without reason)
    3- ( ) dismissed

WHY:
28. 1- ( ) work was too hard
    2- ( ) work was too far
    3- ( ) too slow for the job
    4- ( ) couldn't get along with fellow workers
    5- ( ) other:_____

_____

ARE YOU NOW TAKING ANY COURSES WHICH MIGHT HELP YOU GET A JOB (OR PROVIDE NEW SKILLS FOR YOUR CURRENT JOB):
29. 1- ( ) Yes
    2- ( ) No

Why:_____

30. 1- ( ) no place nearby
    2- ( ) not interested
    3- ( ) too tired
    4- ( ) other_____

_____
    5- ( ) not applicable

INTERPERSONAL RELATIONS QUESTIONNAIRE

The Interpersonal Relations Questionnaire attempted to periodically assess the client's view of the quality and quantity of his human contacts, and of the contrast between his current and past situations. The seven items were:

1. During the last four months did any member of your family (or close relatives or friends) come to visit you?

	Score
( ) 1. Yes	1
( ) 2. No	3
( ) 3. Have no family or friends outside of institution	3

2. Do you spend time with your friends and companions:

	Score
( ) 1. Frequently (a good part of the day)	1
( ) 2. Occasionally (a few times a week)	2
( ) 3. Have no friends	3

3. How many close friends do you have now? (Insert number)

Score
1
3

4. (Asked only of those now in foster homes) As compared with where you lived before, your own family or the institution from which you came, do you now have:

	Score
( ) 1. More friends	1
( ) 2. The same number of friends	1 if item 3 scored 1 3 if item 3 scored 3 2 if does not apply
( ) 3. Less friends	3

5. Do you spend most of your time alone or talking and engaging in activities with other people.

	Score
( ) 1. Alone	3
( ) 2. With others	1
( ) 3. Both equally alone and with others	2

6. When you feel down in the dumps is there anyone who tries to cheer you up:

	Score
( ) 1. Yes	1
( ) 2. No	3

7. Is there someone whom you can talk things over with when you have something on your mind. (Do not include caseworker.)

	Score
( ) 1. Yes	1
( ) 2. No	3

III. INDEX OF FUNCTIONAL ACTIVITIES:

C = Complete: the activity can be performed completely without assistance.

P - Partial: the activity can be performed only with assistance for part of the activity.

N = Not at all: the patient is unable to perform any part of the activity without active assistance/ or can not perform at all.

OVERALL VIEW

LEVEL AMBULATION:

1. 1- ( ) C
   2- ( ) P
   3- ( ) N

ELEVATION:

2. **Stairs and Curb:**
   1- ( ) C
   2- ( ) P
   3- ( ) N

3. **Car (own):**
   1- ( ) C
   2- ( ) P
   3- ( ) N

4. **Subway:**
   1- ( ) C
   2- ( ) P
   3- ( ) N

5. **Bus:**
   1- ( ) C
   2- ( ) P
   3- ( ) N

BED ACTIVITIES:

6. 1- ( ) C
   2- ( ) P
   3- ( ) N

PERSONAL HYGIENE:

7. 1- ( ) C
   2- ( ) P
   3- ( ) N

DRESSING:

8. 1- ( ) C
   2- ( ) P
   3- ( ) N

EATING:

9. 1- ( ) C
   2- ( ) P
   3- ( ) N

WRITING:

10. 1- ( ) C
    2- ( ) P
    3- ( ) N

SPEECH:

11. 1- ( ) Completely Intelligible
    2- ( ) Partially
    3- ( ) Hard to understand

PREPARATION & COOKING OF FOODS:

12. 1- ( ) C
    2- ( ) P
    3- ( ) N

LIGHT HOUSEHOLD TASKS:

13. 1- ( ) C
    2- ( ) P
    3- ( ) N

SHOPPING, MARKETING:

14. 1- ( ) C
    2- ( ) P
    3- ( ) N

INDEX OF FUNCTIONAL ACTIVITIES

SPECIFIC

MOBILITY:
15. 1- ( ) Bedfast
    2- ( ) Wheelchair dependent
    3- ( ) Ambulatory dependent

IN HOUSE:
16. 1- ( ) Wheelchair independent
    2- ( ) Ambulatory independent

OUTSIDE:
17. 1- ( ) Ambulatory dependent
    2- ( ) Ambulatory independent

MECHANICAL SUPPORTS (Appliances):
18. ( ) Wheelchair

19. ( ) Braces

20. ( ) Crutches

21. ( ) Canes

22. ( ) Prosthesis

TRANSFER & ELEVATION "Without Assistance"
23. ( ) From bed to chair

24. ( ) From chair to bed

25. ( ) From chair to chair

26. ( ) Sitting to standing

27. ( ) Walking (about 50 ft.)

28. ( ) Climbing stairs (5 steps of 1 flight)

WHEELCHAIR MOBILITY:
29. ( ) Propel - forward, backward, turn
30. ( ) Up and down ramp

31. ( ) Through and close door

PERSONAL CARE:
Eating:
32. ( ) Independent (without special equipment)

33. ( ) Independent with special utensils

34. ( ) Partial aid - needs food to mouth assistance

35. ( ) Has to be fed

BATHING:
36. ( ) Independent (assistance)

37. ( ) Needs assistance in transfer to bathtub/or shower

    ( ) Washes without assistance

38. ( ) Dries self without assistance

DRESSING:
Puts on:

39. ( ) underclothes W A

40. ( ) outer " W A

41. ( ) out-of-door clothes W A

42. ( ) shoes W A

43. ( ) ties laces W A

44. ( ) ties tie W A

45. ( ) buttons/handles zippers W A

TOILET:
46. ( ) all activities W A

47. ( ) moves onto toilet W A

48. ( ) adjusts clothes W A

49. ( ) cleans self W A

50. ( ) use of independent bed pan or commode

GROOMING:

51. ( ) brushes teeth W A

52. ( ) shaves/or make-up W A

53. ( ) combs hair W A

54. ( ) brushes hair W A

55. ( ) uses handkerchief

MANIPULATIVE ACTIVITIES:

56. ( ) smokes cigarette W A

57. ( ) lights cigarette W A

58. ( ) uses light switches W A

59. ( ) turns book pages W A

60. ( ) reads newspaper W A

61. ( ) uses telephone for calls W A

62. 1- ( ) writes legibly
2- ( ) " fairly well
3- ( ) cannot write

63. ( ) puts on appliances W A

64. ( ) removes appliances W A

65. ( ) turns on faucets W A

66. ( ) manages pillow, blankets W A

C A R D 2

SPEECH:

1. -1 ( ) Speech is intelligible; can be understood without difficulty by a stranger. Speech is well developed with clear enunciation.

-2 ( ) Speech is intelligible; however, minor impediments are noticeable.

-3 ( ) Some difficulty in becoming understood by a stranger; while speech is awkward he is able to get his ideas across.

-4 ( ) Speech is hard for stranger to understand; difficult for person to get ideas across as speech is barely intelligible.

-5 ( ) Almost totally unable to communicate by speech; speech is unintelligible or person is totally without speech.

HEARING:

2. -1 ( ) No functional hearing loss.

-2 ( ) Slight functional loss; generally adequate for normal conversational requirements.

-3 ( ) Moderate functional loss; capable of getting the gist of normal conversation.

-4 ( ) Severe functional loss; has great difficulty in following normal conversation.

-5 ( ) Complete functional loss; unable to follow normal conversation.

CONTINENCE:

3. -1 ( ) Double incontinence

-2 ( ) Periodic incontinence urine/bowel

-3 ( ) Continent, social

-4 ( ) Continent

PATIENT ASSESSMENT

MEDICAL:

Diagnosis:

1. 1- ( ) Polio
   2- ( ) C. P.
   3- ( ) M. D.
   4- ( ) Encephalitis
   5- ( ) Arthritis

   6- ( ) _____
   7- ( ) _____
   8- ( ) _____

Prognosis:

2. 1- ( ) Improvement possible
   2- ( ) Stabilized-Maintenance
   3- ( ) Slow deterioration
   4- ( ) Fast deterioration

Is Patient Utilizing Physical Potential:

3. ( ) of arms
4. ( ) of legs

_____

Onset of Illness:

5. ( ) Birth
6. 1- ( ) sudden
   2- ( ) slow
7. 1- ( ) below 5 years - Age ( )
   2- ( ) 5-10
   3- ( ) 10-15
   4- ( ) 15-21
   5- ( ) over 21

Character of Onset:

8. 1- ( ) Unnoticed
   2- ( ) Painful (immediately)

General Health:

9. 1- ( ) Good
   2- ( ) Fair
   3- ( ) Poor

Appearance:

10. 1- ( ) Good
    2- ( ) Fair
    3- ( ) Poor

Does Patient Complain of Physical Pains:

11. 1- ( ) Frequently
    2- ( ) Sometimes
    3- ( ) Hardly ever

Other Major Illness: Hospitalized for:

12. ( ) Cardiovascular 13. ( )
14. ( ) Neurological 15. ( )
16. ( ) Respiratory 17. ( )
18. ( ) Gastro-intestinal 19. ( )
20. ( ) Muscular-skeletal 21. ( )
22. ( ) Genitourinary 23. ( )
24. ( ) Metabolic or Allergic 25. ( )

Other Hospitalizations:

26. ( ) No. of
    From _____ to _____

Reason for:

27. 1- ( ) Condition directly related to handicap
    2- ( ) Not necessarily related to handicap

Type of Care Patient Has Had:

28. ( ) Custodial
29. ( ) Active Rehabilitation
30. ( ) Medical
31. ( ) Post Operative

PHYSICAL APPEARANCE:

32. ( ) Good, except for wheel chair confinement
33. ( ) One arm is affected; dragged deformed, awkward
34. ( ) One leg is affected; dragged deformed, awkward
35. ( ) One side of body deviates from normal: leg and arm
36. ( ) Cannot control movements of some parts of body
37. ( ) Movements of head are

not controlled

38. ( ) Facial gestures are awkward

GENERAL APPEARANCE:

39. 1- ( ) Attractive
    2- ( ) Somewhat awkward
    3- ( ) Generally awkward

Patient's Opinion of the Severity of His Handicap:

40. 1- ( ) MILD: Does not see it as necessarily interferring with possible job opportunities or most activities of daily living.
    2- ( ) MODERATELY SEVERE: Sees some possibility for employment; needs a good deal of assistance in ADL.
    3- ( ) SEVERE: Sees almost no possibility for employment; needs assistance in almost all ADL.

Compared to Fellow Patients with a Similar Handicap Patient Feels He is:

41. 1- ( ) better off
    2- ( ) same as
    3- ( ) worse off
    4- ( ) doesn't know/or say

Compared to Other Handicapped Persons in the Hospital Patient Feels He is:

42. 1- ( ) better off
    2- ( ) same as
    3- ( ) worse off
    4- ( ) D. K.

Patient's Attitude Toward His Medical Care in the Hospital:

43. 1- ( ) complains frequently
    2- ( ) reacts indifferently
    3- ( ) always praises doctors and staff

Patient's Participation in the Treatment Plan:

Patient's Opinion

44. 1- ( ) cooperative
    2- ( ) uncooperative

Hospital Staff Opinion

45. 1- ( ) cooperative
    2- ( ) uncooperative

Worker's Opinion

46. 1- ( ) cooperative
    2- ( ) uncooperative

Patient's Opinion of Why He Has Not Yet Been Discharged:

47. ( ) He does not want to be
48. ( ) No job available
49. ( ) Family can't take him
50. ( ) No home available

SOCIAL: (in hospital)

Relationship with Hospital Staff: Interaction (meeting, talking, etc.)

	Frequent	Occas.	Rare
51. M.D.'s	1- ( )	2- ( )	3-( )
52. Nurses	1- ( )	2- ( )	3-( )
53. P.T.'s	1- ( )	2- ( )	3-( )
54. Social Worker	1- ( )	2- ( )	3-( )
55. Other Patients	1- ( )	2- ( )	3-( )

Interpersonal Feelings:

	Warm	Perfunctory	Hostile
56. M.D.'s	1- ( )	2- ( )	3- ( )
57. Nurses	1- ( )	2- ( )	3- ( )
58. P.T.'s	1- ( )	2- ( )	3- ( )
59. Social Worker	1- ( )	2- ( )	3- ( )
60. Other Patients	1- ( )	2- ( )	3- ( )

Relation with Other Patients:

61. 1- ( ) Leader: takes the initiative in discussion, activities
    2- ( ) Follower: enjoys group activities, a joiner
    3- ( ) Isolate: withdraws from participation with others

Patient's Perception of Reasons for Discharge of Patients:

62. ( ) was able to get a job
63. ( ) had a family to go to
64. ( ) had a foster home to go to

Previous Attempts re: Discharge:

65. 1- ( ) no active attempt by anyone was ever made
    2- ( ) was placed in a foster home; returned to institution
    3- ( ) was turned down by agencies for placement

Living Situation Prior to Hospitalizations re: Kind of Housing:

66. 1- ( ) good
    2- ( ) adequate
    3- ( ) poor

ENVIRONMENTAL CHANGE DATA

Name of Patient: _____ No. ( )

Name of Family: _____

Address of Family: _____

(Date) Moved on: _____ To: (Family) _____

Address: _____

REASONS FOR MAKING THE CHANGE: (Views of the:)

Patient: _____

_____

_____

Family: _____

_____

_____

S.W.: _____

_____

_____

To S.W.: In your opinion who was the major factor forcing the environmental change?

( ) Family ( ) Patient ( ) _____

II. SOCIAL AND PERSONAL EVALUATION

MARITAL STATUS:
1. 1- ( ) Married
   2- ( ) Single
   3- ( ) Widowed
   4- ( ) Divorced

RACE:
2. 1- ( ) Negro
   2- ( ) White
   3- ( ) Other ( )

ETHNIC BACKGROUND:
3. 1- ( ) Irish
   2- ( ) Italian
   3- ( ) Polish
   4- ( ) Russian
   5- ( ) East European (Other)
   6- ( ) West European
   7- ( ) Great Britian, Scandinavian
   8- ( ) American
   9- ( ) Other ( )

AGE:
4. Date of Birth: ( )
   1- ( ) below 25
   2- ( ) 25-29
   3- ( ) 30-35
   4- ( ) 36-40
   5- ( ) 41-50
   6- ( ) 51-60
   7- ( ) 61-65
   8- ( ) over 65

PLACE OF BIRTH:
5. 1- ( ) New York
   2- ( ) United States (other than New York)
   3- ( ) Foreign born

RELIGION:
6. 1- ( ) Protestant
   2- ( ) Jewish
   3- ( ) Catholic
   4- ( ) Other ( )

PRACTICE RITUAL:
7. 1- ( ) Yes
   2- ( ) No

CHURCH ATTENDANCE:
8. 1- ( ) Yes
   2- ( ) No

EDUCATION:
9. 1- ( ) Completed College
   2- ( ) Some College
   3- ( ) High School Graduate
   4- ( ) Some High School
   5- ( ) Jr. High School
   6- ( ) Completed Grade School

INCOME (Earnings):
10. (Amt.-)
   1- ( ) None
   2- ( ) below $4,000
   3- ( ) $4 - 6,000
   4- ( ) $6 - 8,000
   5- ( ) $8 - 10,000
   6- ( ) Over $10,000

OTHER INCOME:
11. (Amt.-)
   1- ( ) less than $1,000
   2- ( ) $1 - 2,000
   3- ( ) $2 - 3,000
   4- ( ) above $3,000

OCCUPATION:
12. 1- ( ) Professional
   2- ( ) Managerial
   3- ( ) Small business (owner)
   4- ( ) Skilled (electrician, etc.
   5- ( ) Sales
   6- ( ) Clerical: typist, etc.
   7- ( ) Unskilled laborer
   8- ( ) Service (nurse, etc.)
   9- ( ) Other (housewife)
  10- ( ) Not applicable

OCCUPATIONAL PATTERN:
13. ( )
   1- ( ) Stable for many years
   2- ( ) Recent changes
   3- ( ) Constant movement from job to job
   4-)) Not employed for many years

VOCATIONAL HISTORY

EMPLOYMENT HISTORY

1. ( ) Was at one time employed

Type of organization or company

2. 1- ( ) Building or constr.
   2- ( ) Transportation
   3- ( ) Manuf., assembly or factory
   4- ( ) Gov't (Federal, State, County, City)
   5- ( ) Professional
   6- ( ) Communications
   7- ( ) Retail business
   8- ( ) Other_____
   9- ( ) Not employed

Place of Employment:

3. 1- ( ) Outside of home; regular
   2- ( ) Outside of home; sheltered

Workshop:

   3- ( ) Home work
   4- ( ) Other_____
   9- ( ) Not employed

Was this Job:

4. 1- ( ) Full time (35-40 hrs.) full week)
   2- ( ) Part time (25 or more)
   3- ( ) Other_____

No. of Months Last Job was Held:

5. 1- ( ) less than 6 months
   2- ( ) 6 months - 1 year
   3- ( ) more than 1 year
   9- ( ) never employed

(Refers to previous jobs)

No. of Months Job Prior to One in Question was Held:

6. 1- ( ) less than 6 months
   2- ( ) 6 months - 1 year
   3- ( ) more than 1 year
   9- ( ) not employed

Salary: (for job in question 5)

7. 1- ( ) under $50 a week
   2- ( ) $51-75 " "
   3- ( ) $76-100 " "
   4- ( ) over $100 " "
   9- ( ) not employed

Salary: (for job in question 6)

8. 1- ( ) under $50 a week
   2- ( ) $51-75 " "
   3- ( ) $76-100 " "
   4- ( ) over $100 " "

How Many Years Ago was Last Job Held:

9. 1- ( ) less than 1 year
   2- ( ) 1-2 years
   3- ( ) 2-5 years
   4- ( ) more than 5 years
   9- ( ) never employed

How was Job Obtained? Through-

10. 1- ( ) Answered ad
    2- ( ) Job hunting
    3- ( ) Private agency

NAME:_____

    4- ( ) Public Agency

NAME:_____

    5- ( ) Friend
    6- ( ) Family
    7- ( ) New York Service
    8- ( ) Other_____
    9- ( ) Not employed

Difficulties Related to Job:

Subject Complains of:

11. 1- ( ) None
    2- ( ) Working hrs. too long
    3- ( ) Work environment
    4- ( ) Transportation difficulties
    9- ( ) Not employed

Subject Left Job Because of:

12. 1- ( ) Found a better job
    2- ( ) Too look for a better job
    3- ( ) Job was temporary
    4- ( ) Health
    5- ( ) Transportation difficulties
    6- ( ) Changed residence
    7- ( ) Couldn't get along with boss
    8- ( ) Couldn't get along with employees
    9- ( ) Not employed or is on job

Relationship with Employees: (Most of Them)

13. 1- ( ) Good
    2- ( ) Fair
    3- ( ) Poor
    9- ( ) Not employed

Relationship with Boss or Supervisor:

14. 1- ( ) Good
    2- ( ) Fair
    3- ( ) Poor
    9- ( ) Not employed

If Discharged, Reason for Removal:

15. 1- ( ) Job was no longer necessary
    2- ( ) Employer cut back on work or went out of business
    3- ( ) Subject's work production was lower than it should have been
    4- ( ) Other_____
    9- ( ) Not employed

VOCATIONAL INTERESTS:

Vocational Training?

16. 1- ( ) Yes
    2- ( ) No
17. Type of:_____

Where:

18. 1- ( ) High School
    2- ( ) Trade School
    3- ( ) Rehabilitation Center
    4- ( ) In institution where currently located
    5- ( ) Other_____
    9- ( ) None

EDUCATION BACKGROUND:

Schools Attended: Elementary School

19. 1- ( ) Regular
    2- ( ) Special
    3- ( ) Private Home Tutor
    4- ( ) Bd. of Educator Home Tutor

High School:

20. 1- ( ) Regular
    2- ( ) Trade
    3- ( ) Commercial
    4- ( ) Private Home Tutor
    5- ( ) Bd. of Ed. Home Tutor
    6- ( ) Never attended

High School:

21. 1- ( ) Graduated from
    2- ( ) Did not graduate from
    9- ( ) Never attended high school

College:

22. 1- ( ) Regular - Academic
    2- ( ) Special_____
    9- ( ) Never attended

23. 1- ( ) Graduated from college
    2- ( ) Had some course work in college
    9- ( ) Never attended

Why Subject Discontinued Schooling:

24. 1- ( ) Health reasons
    2- ( ) Boredom
    3- ( ) Held back in school
    4- ( ) Financial
    5- ( ) Other_____
    6- ( ) Graduated

IV. STYLE OF LIFE OF APPLICANT AND FOSTER PARENTS

PETS:
1. ( ) Dog (s)
2. ( ) Cat (s)
3. ( ) Canary: bird
4. ( ) _____
5. ( ) T.V. - No. of sets (Code as is)

6. 1- ( ) Arises at 6-7 A.M.
   2- ( ) " " 7-8 A.M.
   3- ( ) " " 8-9 A.M.
   4- ( ) " " 9-10 A.M.
   5- ( ) " " 10 or later

DRINKS ALCOHOLIC BEVERAGES:
7. 1- ( ) Occasionally
   2- ( ) Frequently
   3- ( ) Never

GETS "HIGH" OR DRUNK
8. 1- ( ) Occasionally
   2- ( ) Frequently
   3- ( ) Never

9. ( ) Would object to patient drinking alcohol

10. ( ) Would object to patient drinking any intoxicating beverage

Prefers: (list only one)
11. 1- ( ) Tea
    2- ( ) Coffee
    3- ( ) Milk

SMOKES:
12. 1- ( ) Cigarettes

Brand: _____

13. ( ) Objects to smoking

IS INTERESTED IN:
14. ( ) Reading magazines - Sports
15. ( ) General (Life, Look, Time)
16. ( ) Specialty

READING BOOKS:
17. ( ) Detective Stories
18. ( ) Love Stories
19. ( ) Popular Novels
20. ( ) Does not read books

NEWSPAPER READ REGULARLY:
21. ( ) New York Times
22. ( ) New York Post
23. ( ) Journal American
24. ( ) World Telegram
25. ( ) Daily News
26. ( ) Daily Mirror
27. ( ) Foreign Language
28. ( ) Local _____
29. ( ) Takes course at some school

MUSIC: (Enjoys primarily)
30. 1- ( ) Classical
    2- ( ) Popular
    3- ( ) Folk

31. 1- ( ) Phonograph (regular- has a
    2- ( ) Stero-Hi Fi

32. ( ) Record Collection - owns a

SPORTS: (Enjoys primarily)
33. ( ) Baseball, Football, Soccer
34. ( ) Boxing, Wrestling
35. ( ) Fishing, Boating
36. ( ) Tennis, Horseback Riding

FOOD HABITS: Eats mainly:
37. 1- ( ) American Type Food
    2- ( ) Foreign " "
    Type: _____

38. ( ) Frequently eats out at restaurants (at least once a week)
39. ( ) Enjoys cooking
40. ( ) " baking

HOBBIES:
41. ( ) Cards
42. ( ) Checkers, Mahjong, Bingo, etc.
43. ( ) Chess, Bridge
44. ( ) Collects some objects (stamps, antiques)

Type _____

T.V. PROGRAM FAVORITES:

Enjoys mostly:

45. ( ) Westerns
46. ( ) Crime - Lawyer dramas
47. ( ) Situation Comedies
48. ( ) Soap Operas (daytime)
49. ( ) Serious drama, public affairs
50. ( ) Other: _____

SOCIAL WORKERS INTERVENTION:
CONTACTS MADE ON BEHALF OF CLIENT

DW Contact: (Incl. special services)

Reason: Checks not received; supplies needed; transportation; procedural question about client's eligibility for something; including medical; status of case re client's situation in placement, etc.; additional money needed for food, rent, clothing, budget; approval of housing, placement re client's move; re transfer of case; re summary information; re member of client's family; re vocational testing; re personal and psych. problems of client, general condition re job.

To DVR

Reason: Re checks not received; re school; money needed for food, rent, clothing; re transportation; re job; re special care or equip. for client (psych., phys. therapy), medical; procedural question about client's eligibility for something (e.g. sharing apartment with another handicapped person) training program; appointments for, with, about client re evaluation records, transfer, referral of client.

To Hospitals (incl. special surgery)

Reason: Re client's condition; re medical records, referral, evaluation; re member of client's family; re member of foster family; re medication, treatment, care; transfer of case, closing of case; re equipment for client's transportation; to make appointment; re client's move to hospital, to discharge from, arrangements for trial visit; DW investigation.

To Driver

Reason: Re client missing school; re checks, behavior, attitude; to make plans for picking up client; to put up apparatus for client.

To Hotels, Real Estate or Agents

Reason: Re client missing school; re checks, behavior, attitude; to make plans for picking up client; to put up apparatus for client.

To Doctors, Psychiatrists, Physical Therapists, Med. SWS, Vocational Counselors

Reason: Re client's condition; medication, diet, etc.; for

special treatment; client's future plans, discharge, placement; re client's record, referral; re money; re transfer of case.

To ICD

Reason: Re training program; re client's adjustment to program; closing of client's case, re referral to another organization; re request for special services; (physical therapist); re money; re foster home; re recreation; re job; re appointment.

To C.P. Centers

Reason: Re client's eligibility; re transportation; re information on recreational programs; re records from another organization; re referral; re report on client, evaluation.

To U.C.P.

Reason: Re transportation; re acceptance of client in special workshops, recreationl program, vocational; re request for records for another organization, referral; re client's attendance, participating program; re treatment, counseling; re special equipment, supplies; re payment for - money in general; re job; re client's move, placement.

To Nursing Homes, Salvation Army, Etc.

Reason: Re boarding client; re boarding member of client's family; re client's eligibility for something; re supplies for client, money; to give information concerning client's placement, camp; re discharge.

To Business Firms

Reason: Re special supplies (railings); re transportation; re repair of equipment; re job possibilities; re retirement pay.

To Veterans Administration

Reason: Re check

To NYSES, JVB, DER, JOB, Federation Employment Service, Abilities, Red Cross

Reason: Re employment; re transportation; particularly in program; for special purpose (e.g. day off); re appointment.

A.A.

Reason: Re group for client; re group for member of client's family.

Catholic Home Bureau

Reason: Re member of client's family; re client visit to member of family; re information concerning client; to advise on client's situation.

Probation Office

Reason: Re report.

Camp

Reason: Client's eligibility; dates, etc. of camp; camp forms; client's progress, participation; appointment for interview.

To I.P.M.R.

Reason: to inform of client's situation; bills, money; client's progress; client's eligibility for something; medical and other treatment; employment; appointment; referral; future plans.

To Client's Family

Reason: Money; client's placement; background history; client's reaction to TV, to make appointment.

To Schools

Reason: Special facilities.